

SHRC working papers 3

Strengthening Public Health Systems

Report of a Study on
Issues of
Workforce Management,
Rationalisation of Services
and
Human Resource Development
in the
Public Health Systems
Of Chhattisgarh State

AN SHRC PUBLICATION

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Strengthening Public Health Systems

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STRENGTHENING PUBLIC HEALTH SYSTEMS

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On Workforce Development & Rationalisation Issues

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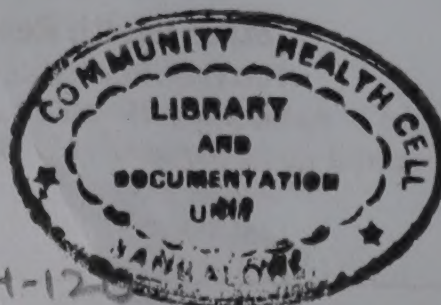
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Foreword

There is increasing recognition that the challenge of providing universal access to quality health care requires primarily the building up of robust health care systems. In the context of a socio-economically challenged state like Chhattisgarh the foundation on which such a health care system rests is necessarily a strengthened, effective public health system. And strengthening the public health system requires a systemic approach. A systemic approach implies that in parallel to making investments in infrastructure, manpower, equipment and supplies there must be the development of management and professional capabilities and the development of appropriate organisational strategies and that all these must develop in parallel to each other. The Health Sector Reforms under the Sector Investment Programme constitute a major effort to stimulate and catalyse this sort of health system development.

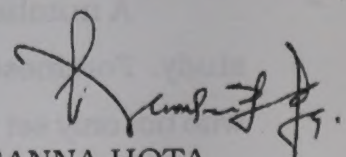
This study on workforce management and rationalisation of services and human resource development in the public health system done by the State Health Resource Center is a welcome addition to the existing studies done in this area. This study builds a baseline of current state of health services in the state, documents current organisational practices and their lacunae and evolves a set of pragmatic recommendations. This study has also examined with compassion and understanding the factors affecting the motivation of cadre at different levels.

Some of these recommendations are innovative and lend themselves to immediate implementation with existing resources. A follow up study that defines the financial implications of these recommendations and makes the case for more budgetary allocation as well as suggests measures for supplementary resource generation would go a long way to facilitate the implementation of many more suggestions of this study.

Some of the major recommendations of this study -like on transfer policy and tenure- are reiterating well-known issues and remedies. Their implementation rests on the ability to negotiate acceptance by the political leadership of the state. Finally the far reaching recommendations for legislative policy initiatives would move us closer to the realisation of health care as a constitutionally mandated basic right of citizens. This would require much more discussions not only within governments, but within civil society as well, for generating the political will for such a step. Considerable legal, administrative and financial detailing would be needed before such a legislative initiative can take place.

I need to congratulate the department of Health of Chhattisgarh for its dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants to assist a state level team led by the State Health Resource Center to do a study of this magnitude so as to build state level capabilities in policy studies. Their action in having had a serious dialogue with all stakeholders before finalising the recommendations is also worth emulating. I hope this study is widely shared at all levels and contributes to the health sector reform process not only in the state of Chhattisgarh but in all the Empowered Action Group states.

I am sure that this excellent report will galvanise the leaders and administrators of the primary health care system in Chhattisgarh state, enabling them to go into details of implementation based on the lessons drawn from this study.



PRASANNA HOTA
Secretary to Govt. of India, 2004
Dept. of Family Welfare

Acknowledgements

The State Health Resource Centre would like to place on record its acknowledgement of all the following who have assisted in the design and completion of this study and who contributed to drawing up its final recommendations.

The Study Group

Dr. V. R. Muraleedharan, Professor in Economics from the department of humanities, Indian Institute of Technology, Madras and a well known health economist helped us in the design of the study, to finalise the questionnaires, accompanied us on field visits and finally helped with interpretation of data and the drafting of the report.

Dr. Vinod Arora, Dean of the Indian Institute of Health Management and Research, Jaipur interviewed the senior officials and conducted the study on organisational and motivational culture.

Dr. Thelma Narayan, Director Community Health Cell Bangalore and one of the joint convenors of the Jan Swasthya Abhiyan (People's health movement), a health policy expert, assisted in a critical reading of the instruments and the draft reports of the study.

Dr. K. Madan Gopal, Adviser, DANIDA Support Unit and Mr. Biraj Patnaik Regional Manager, ActionAid India were consultants assisting in interviews and field visits and a critical reading of the drafts.

Dr. Shailendra Patne, a faculty member of the Medical College at Bhopal and an activist of the Madhya Pradesh Vigyan Sabha, played a major role in supervising the complete tabulation and analysis of the data and helped with field visits.

Contributing Officials

A number of senior officials also contributed in a significant way to the study. Foremost amongst them was Dr. Alok Shukla state health secretary, who not only set us the mandate of the study but also was available for discussion at every stage and ensured that we came up with implementable

Chap recommendations- not merely gratuitous, self-evident observations. Himself a post graduate in surgery with a long track record in health administration, his experience and insights have contributed to the final outcomes of this study in a major way.

Another official who contributed through discussions in a significant way was Dr. D. K. Sen, Joint Director in charge of establishment who was the source of almost all the secondary data we have used and who provided us with sharp insights on workforce issues. Dr. R. N. Netam, Chief Medical Officer, Rajnandgaon was another major source of information and ideas on the problems of the district and sub-district level.

Other officials who contributed were Dr. R. K. Rajmani Director Health Services, Dr. G. S. Badesha, the Director of ISM, Dr. R. C. Bholla, the Director of Medical Education, Dr. A. T. Dabke, Dean Pt. J. N. M. Medical College, Raipur and the Joint Directors, Dr. B. S. Sarwa and Dr. H. L. Ratre.

One of our most important acknowledgements is reserved for Mr. J. P. Mishra, consultant ECTA who initially mooted the study and at every stage actively discussed its processes and ensured that it was done in a comprehensive and participatory manner. In his vision the axis around which the entire health sector reform process revolves is this study and further such studies in related areas.

Supporting Team

We are grateful to AISECT and its regional manager Mr. Javed, for having helped with the recruitment and monitoring of the researchers for data collection for the entire chosen sample of 32 blocks. Dr. Premanjali Deepti Singh, Programme Coordinator SHRC and Ms. Sarika Sinha, Programme Officer Action-aid assisted in training the researchers and in coordination of the work. SHRC programme coordinator, Mr. V. R. Raman, provided logistic and administrative support. Office support from Mr. Komal Devangan and Mr. Hemlal Kurre is also gratefully acknowledged.

Stakeholder Dialogues

The report has benefited immensely by its presentation and interrogation and discussion with a number of senior officials. Foremost amongst these are

the Union Secretary for Family Welfare Mr. Prasana Hota who found the time to come for a full three hour presentation and discussion of the entire draft report. Himself an experienced health administrator, he contributed many valuable insights with great frankness and forthrightness. We also thank Mr. S. K. Mishra, Chief Secretary, Government of Chhattisgarh who chaired this discussion session with the Union secretary and actively questioned and contributed to the discussions. We also express our gratitude to Mr. Sunil Kumar secretary to the chief minister and an experienced administrator who was able to point out many serious gaps especially on the issue of decentralisation and panchayats thereby enriching the dialogue and the final outcome. Mr. Amit Agrawal, Secretary, IT and a number of other senior officials of the government and all the directorate of health officials who also participated in these stakeholder dialogues are gratefully acknowledged.

We also thank the various employee associations and their representatives (listed in annexure - 4) who participated in the consultations.

Yet another major source of inspiration and ideas for the entire study and key participants in the stakeholder dialogues have been a number of NGOs. Indeed the state advisory committee on health sector reforms, constituted largely by these NGOs had been the first to suggest a study on workforce reforms as part of a comprehensive health sector reform programme.

The dialogue with all these sections enriched the draft report. Many clarifications and modifications from these dialogues have been incorporated into this report before finalising it. We however clarify that the final report expresses the views and recommendations of the study team. Though all senior government officials have contributed to it, the final report does not represent the official view of the government. We thank all the above for their contributions and place on record that the responsibility for any errors that may have crept in, rests only with the director, SHRC.

Dr T. Sundararaman
Director
State Health Resource Center

Chapter - I



Introduction and Terms of Reference



In this chapter, we provide the rationale for the study and its specific objectives.

INTRODUCTION

The formation of a new state provides new opportunities. Though it inherits from its predecessor a policy framework it is open and willing to re-examine this inheritance and reformulate its own policy, drawing upon lessons from all the states. The Government of the State of Chhattisgarh is now engaged in the process of assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make greater impact on the health status of the people.

Chhattisgarh's inherited, at the time of its creation, a health status well below the national average. Its performance on the delivery of key reproductive and child health services was also well below the national average. To climb out of this situation it has launched a number of initiatives. In parallel to these initiatives it has also planned and sanctioned a number of studies to develop an overall understanding of the functioning of the public health system and the possibilities for rationalisation of health services, human power development and workforce management that would lead to a better outreach, utilization and quality of health care services.

Any attempt to explore policy options for human power development must be based on an empirical understanding of the conditions under which the present system functions and how it responds to the challenges that arise from within and outside the healthcare system. Our understanding of the prevailing conditions and search of policy options should also be guided by an appreciation of the capacity of the system to respond to immediate challenges as well as those that are likely to occur in the future.

We need to understand not only the existing constraints, but how they came about and why they persist.

Terms of Reference

Given these overarching concerns, the present study attempts to address the following three questions:

- How adequate are the existing human and material resources at various levels of care (namely from sub-centre level to district hospital level) in the state; and how optimally have they been deployed?
- What factors contribute to or hinder the performance of the personnel in position at various levels of care?
- What structural features of the health care system as it has evolved affect its utilisation and its effectiveness?

In more specific terms, the study would

- ◆ Examine the current work load of various functionaries (field and higher level functionaries) in the state.
- ◆ Examine the organizational and motivational factors that affect performance of health functionaries.
- ◆ Examine current training strategies.
- ◆ Examine peoples' perception of health functionaries and facilities.
- ◆ Examine the availability and utilization of existing facilities (this will involve a mapping of facilities, personnel in position, vacancies, workload, budget, types of services available including the extent of extension services provided, etc.).
- ◆ Examine the current policies and implementation with respect to recruitment, posting, transfer, and career planning.

Together, these specific studies will help the state planning machinery in the following ways

- ◆ Lay down norms for various facilities and services and identify constraints on access to and optimal utilization of basic facilities (geographic, personnel, and systemic).
- ◆ Project additional requirements for health human power. As part of this component, this study will also identify competencies and social skills for various functionaries.
- ◆ Identify organizational issues and policy processes to address motivational factors that affect performance of health sector personnel.
- ◆ Suggest organizational policies including appropriate recruitment and transfer and career planning.
- ◆ Identify potential for partnership with the private sector and suggest ways to go about this.
- ◆ Identify components and processes to effect decentralization.

To achieve the above goals we organised the study into three overlapping but distinct sets. These were :

- ☐ Facility Survey
- ☐ Organisational Culture and Motivational Factors
- ☐ Workload Assessment.

It is important to note here the areas that were not included for study.

- ◆ The financing of health care and the cost of health care.
- ◆ People's perceptions of health care facilities and their satisfaction with them.
- ◆ Assessments of burden of disease and review of specific programmes.

- ◆ The mapping of the private sector and the development of a policy framework to facilitate and regulate the growth of the private sector in health. Some aspects of public private partnership were however addressed.

The study team recognises the importance of these areas and has follow up studies in all these areas planned. However, within the time and space available for this study it was considered prudent to limit the terms of reference to the objectives as stated above.

Chapter - II

Methodology



In this chapter we describe the instruments that we used, the personnel that we chose to study and the sampling methodology.

BRIEF OVERVIEW

The study had four broad components.

- ❑ First, a series of interviews were conducted with the senior officials.
- ❑ Second, a number of sample surveys were organised.
- ❑ The members of the study made a number of field visits. The focal group discussions, individual interviews, and discussion with various categories of staff and the public during these field visits form the third component.
- ❑ Fourth was the analysis of secondary data as made available from the state department of health.

A. INSTRUMENTS

Several survey instruments were designed to elicit information on the above issues. More specifically, the following instruments were developed-

- ◆ Questionnaires for facility mapping at Sub-Centres (HSCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs).
- ◆ Questionnaires for study of organizational and motivational factors, and work load of personnel at HSC, PHC and CHC.
- ◆ Organizational and motivational factors among district and state level officials through individual interviews with a prepared interview schedule. Also, a self filled questionnaire based on two instruments called OCTAPACE and MAO-C.

1. The Facility questionnaires studied the following aspects of each facility

- ◆ The area that it serves
- ◆ Staff availability
- ◆ Infrastructure- building, toilets, power, water, communication
- ◆ Drugs and supplies
- ◆ Equipment
- ◆ Services provided

2. The Organisation and Motivation questionnaires

- ❑ for HSC, PHC and CHC staff studied the following aspects
- ◆ Questionnaire based data on; Age, qualification, years of service, perception of their job responsibilities, what tasks they preferred and their understanding of constraints on performance, adequacy of staff, infrastructure, drugs supply equipment, and the organisation of work elements.

- ◆ A study of the work actually carried out in the last week.
- For district and state level officials.
- ◆ Interviews were conducted with the help of questionnaires containing structured and open ended questions by senior consultant with senior state and district officials.
- ◆ Motivation and organisational culture study using the study tool OCTAPACE which studies the following qualities: Openness, Confrontation, Trust, Authenticity, Pro-action, Autonomy, Collaboration and Experimenting.
- ◆ Motivation study using the study tool MAO-C which studies MOTIVES such as: Expert Influence, Control, Extension, Dependency & Affiliation. These motives will help us to understand 12 Processes in Organization. These are Orientation, Inter personal relationships, Supervision, Problem Management, Management of Mistakes, Conflict Management, Communication, Decision making, Trust, Management of Rewards, Risk taking and Innovation and change.

B. SELECTION OF SAMPLE

1. Selection of Sample for Facilities

(Sub-centres, Primary health centres and Community health centres)

There are 16 districts in the state of Chhattisgarh. From each district, we have chosen two CHCs, of which one is geographically “close” to the district headquarter and the other geographically “far” from the district headquarters. Like wise, from each CHC, two PHCs were chosen (with one close and the other far from CHC), and from each PHC, two Sub-centres (with one close and the other far from PHC). As a result, we have a sample of 32 CHCs, 64 PHCs and 128 HSCs for this study.

In selecting the sample units, we have not used any official statistics on service utilization, as they were not very reliable. In addition, they were not readily available at the state capital with programme directorates at the time of designing the study. In the absence of these data (which are typically used in such survey studies), we decided to use the geographical factors outlined above. The assumption here is that, the closer an institution to the headquarter & institution, the better access it has to the services. Alternatively, the farther an institution from the headquarter & the poorer the access to the services. This is likely to get reflected in either higher or lower utilization of services, respectively. Needless to say, there could be several other factors affecting the utilization of services. Some of these will be captured through the present study.

2. Officials interviewed at district and state level

- ◆ Director, Health Services
- ◆ Director Medical Education
- ◆ Director-ISM
- ◆ Joint Director-Establishment
- ◆ Joint Director-leprosy
- ◆ Deputy Director RCH
- ◆ Chief Medical Officers -three.
- ◆ Block Medical Officers- 70 for OCTAPACE and MAO-C study.

3. Personnel at the level of facilities

From each facility level, various cadres of health personnel were chosen for the study:

At HSCs : Multi Purpose Worker (Female) and Multi Purpose Worker (Male)

At PHCs : Medical Officer, Section Supervisor (Male) and Section Supervisor (Female).

At CHCs : Block Medical Officer, Medical Officer, Block Extension Officer and Laboratory Technician.

At PHC and CHC level, the following personnel were excluded from the organisational and motivational survey, though some details about them are present in the facility survey: Pharmacists, Compounders, Dressers, Nurses, Ward boys, Peons, Drivers, Chowkidars (Security), Watermen and Cleaners.

Table- 1 gives details of number and categories of personnel interviewed up to CHC level for this study.

The focal group discussions were with MPWs. - male and female, health supervisors female and male and with BMOs.

Table-1 : Sample of Personnel Studied

Group	Selected	Completed
MPW(F)	132	104
MPW(M)	132	78
SECTOR SUPERVISORS (F)	64	32
SECTOR SUPERVISORS (M)	64	32
Medical Officers	64	42
LAB-TECH.32	24	
Block Ext. Educators	32	24
BMO	32	20

The study team members visited five CHC's, three PHC's and five sub centres. The team also visited 5 Ayurvedic dispensaries.

C. SECONDARY DATA

- ❑ Annual report of the department; The district wise tabulations on facilitating coverage and manpower made available for 11 districts & RCH draft plan.
- ❑ National Family Health Survey data,
- ❑ Report on facilities of the ISM directorate.

D. STUDY PROCESS

It was decided not to outsource the study. This was so decided because to come up with useful and implementable outcomes a high degree of participation and even ownership of the study outcomes by the state's health department is essential. This study approach recognises – that the leadership of the state health department is seized with the major problems and has developed an understanding of its solutions. When we propose reforms, one has to necessarily start from there and build on it, with them – rather than position oneself as an external critic and make largely gratuitous recommendations. Moreover by doing the study with a local team, assisted by national consultants with appropriate expertise, capabilities in such a vital area could be built up inside the state.

The study was decided to be undertaken by State Health Resource Centre with its director Dr.T.Sundararaman leading the team, guided and assisted by three national consultants: The three consultants were chosen amongst those who had adequate past experience of such studies and who could bring in a wide range of expertise. They were:

- ❑ Dr. Vinod Arora, Dean, Indian Institute of Health Management and Research, Jaipur
- ❑ Dr. V. R. Muraleedharan, Professor Economics, Department of Humanities, Indian Institute of Technology, Chennai.
- ❑ Dr. Thelma Narayan, Director, Community Health Cell, Bangalore.

The consultants helped in the study design, in conducting the interviews and in analysing and interpreting the results as well as in report writing.

As a first step, in December 2002, a study design meeting was held where the study team was constituted. Those who participated included the secretary Dr. Alok Shukla, the director Dr. R. K. Rajmani, the director medical education Dr. R. C. Bholla, the dean Raipur medical college Dr. A. T. Dabke, the joint director Dr. H. L. Ratre, Dr. K. Madangopal from Danida Support Unit and Mr. Biraj Patnaik from Action Aid, two chief medical officers Dr. R. N. Netam and Dr. A. K. Dave and Dr. Ms. N. K. Gandhi, head dept of preventive and social medicine. From SHRC Dr. Ms. Premanjali Deepti Singh and Dr. Shailendra Patne and Mr. V. R. Raman participated.

In the next step Dr. Vinod Arora conducted an interview with all the senior officials of the department of health.

Then, with the help of Dr. V. R. Muraleedharan we designed the questionnaires and contracted in AISECT to recruit and monitor a number of suitable personnel from all the chosen blocks for data collection. Dr. Premanjali Deepti Singh and Ms. Sarika Sinha trained the personnel so selected. Another SHRC-recruited team, guided and supervised by Dr. Shailendra Patne, did the tabulation and collation of the data, and preliminary analysis of the data.

The draft report was then prepared by Dr. T. Sundararaman & Dr. V. R. Muraleedharan and circulated widely to various stakeholders and discussions with them were initiated.

Stake Holder Dialogues

Before finalising the report a three-day workshop of stakeholders, with study team members was held from 6th to 8th Nov 2003. Those who were invited and who participated in the dialogue were.

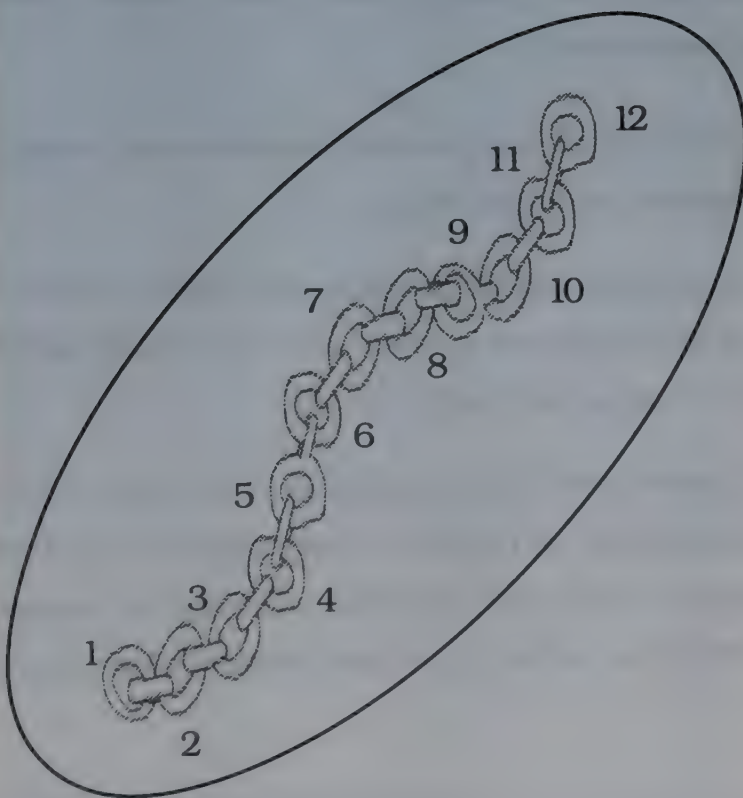
- ◆ Representatives of the major employees associations.
- ◆ Leading civil society partners active in the health sector reform process, most of them were members of the state advisory committee .
- ◆ Senior officials of the directorate- the deputy secretary, all directors, and joint directors.
- ◆ A cross section of junior officials- chief medical officers and district programme officers, senior nurses etc.
- ◆ Senior administrators -the secretary to the chief minister, the chief secretary, the union secretary family welfare and the state health secretary participated in the dialogues.

The views of these various sections are recorded separately in annexure 2.

These dialogues enriched the draft report and many clarifications and modifications were added to the report to finalise the report. We make clear, however, that the final report offers only the final views and recommendations of the study team. Though all senior government officials have contributed to it, the final report does not represent the official view of the government.

Chapter - III

Structure of the Report



In this chapter, we describe the way this report is organised in various chapters and sections.

Structure of the Report

The report first presents the analysis of the situation in each facility level attempting to answer the three central questions that the study set itself. - a definition of the outreach of each facility and an assessment of its performance, looking carefully at the constraints. At the end of each chapter the recommendations as pertaining to the subject matter of that chapter are listed. Then the report goes on to examine structural issues that affect personnel and training at all levels.

We begin, unconventionally, not with the district but with the habitat level services in the form of the sub-centre.

In Chapter 4 we define the sub centre and its outreach and describe its performance and discuss its relationship to constraints due to geography, adequacy of infrastructure, equipment and supplies and due to the level of skills. We also discuss the work allocation and the organisation of work, comparing what is happening with the norms. We also discuss motivational issues as perceived by the staff and examine the data to see how valid these perceptions are.

In Chapter 5 we repeat this for the PHC level. However, we also add in a synthetic treatment, of organisation of work elements of sub-centre and primary health centre taken together. We also consider referral linkages in some detail.

In Chapter 6 we extend the analysis to the CHC. There is a more detailed discussion of laboratory services and of the issues of management and leadership.

In Chapter 7 we discuss the network of services and facilities existing under the indigenous systems of medicine and the question of its integration with the mainstream allopathic facilities resulting in a more effective outreach of the public health system.

In Chapter 8 we discuss the district hospital and the organisation of services at the district level in brief making some general conclusions as regards management at this level along with the issue of decentralisation to districts. We look at policies on a range of support services, including drug procurement and distribution, referral services and ambulance services.

In Chapter 9 we discuss training institutions and in-service training as well as health care human power development policies currently in place.

In Chapter 10 we discuss the structure, and organisation of work at the state level as well as the motivational environment and organisational culture as a whole. In particular we focus on the problems in four key areas of good governance at the state level: *tenure, transfer, promotions and purchases*. In this context, we re-examine and make recommendations on three policy initiatives that are recurrent in our earlier discussion –

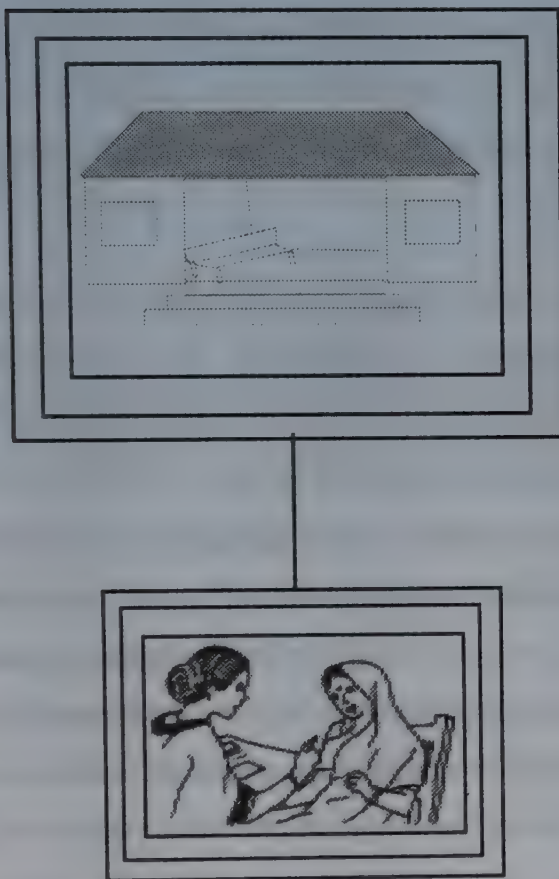
- The question of decentralisation of powers and functions,
- The question of developing management skills
- The option of developing a health management cadre.

In Chapter 11 we take a systemic overview of all the preceeding chapters and the recommendations made so as to organise them into priorities and show their inter-connections and suggest a way of operationalizing the changes proposed. This also helps to define a framework in which decisions can be made between increasing staff strength, reorienting existing staff or contracting services in public-private partnerships. Finally, this section explores the limitations of administrative action, its relationship to political action and a way to move forward.

The recommendations pertaining to each chapter form the concluding part of that chapter itself.

Chapter - IV

Sub-Centers and Multipurpose workers



In this chapter, we shall analyse the adequacy of sub-centers as per the existing norms and the factors that determine their performance. Through an analysis of these factors, we identify specific policy changes that would bring about substantial improvements in their work and thus improve the overall access to and utilisation of good quality public health services made available to the people.

Introduction

The Health sub-centre and the multipurpose health worker cadre serving in it is the backbone of all public health in the state. By numbers the multipurpose health worker is the largest cadre in the health department. It has a larger outreach than almost any other cadre amongst all government employees. By salary it is along with the school teacher the best paid of all government employees who can be posted at the village level. And by work definition almost every component of public health is implemented through them. Defining the distribution, structure and functioning of sub-centers and optimising the processes of recruitment, training, cadre management, organisation and motivation for this force is therefore a central issue of the public health sector.

ADEQUACY OF SUB-CENTRES

Currently there are 3893 sub centers in the state. There are also 16 urban family health service centers and 8 urban health posts and 23 urban civil dispensaries that function.

The population of Chhattisgarh by the 2001 census is 207, 95,956(207.96 lakhs). Of the 146 blocks in the state, 85 blocks are tribal while the rest (61) are non- tribal. The population density is greater in non-tribal blocks and the distribution of population between tribal and non-tribal blocks is roughly equal in both areas.

Of the urban population of 41.7 lakhs (by 1991 census) about half would be in the major municipal corporations, namely Raipur, Bilaspur, Rajnandgaon, Durg (including the steel city of Bhilai), Korba, Raigarh, Janjgir and Jagadapur. The urban health system has only 16 family welfare services, 8 urban posts and 23 civil dispensaries to cater to the entire state. Even these are mainly in the largest urban agglomerations accounting for a population of about 25 lacs. The remaining 15 lacs are in rural towns and are covered by the rural primary health care network. One obvious conclusion is that the larger urban agglomerations are underserved by peripheral public health care facilities and this needs to be addressed urgently as a large part of the population is below the poverty line and faces a crisis of health care. The focus of this study was, however, on the main primary health care network defined to mean CHCs, PHCs and HSCs. This primary health care network caters to about 185 lakhs. If we assume that the rural population is roughly divided between tribal and non-tribal areas, we estimate that we would require about 4590 sub-centers, which indicates a short fall of 693 sub-centers overall.

The district wise disaggregation of this data on HSCs is shown in table-2.

Table-2: Subcentre adequacy data

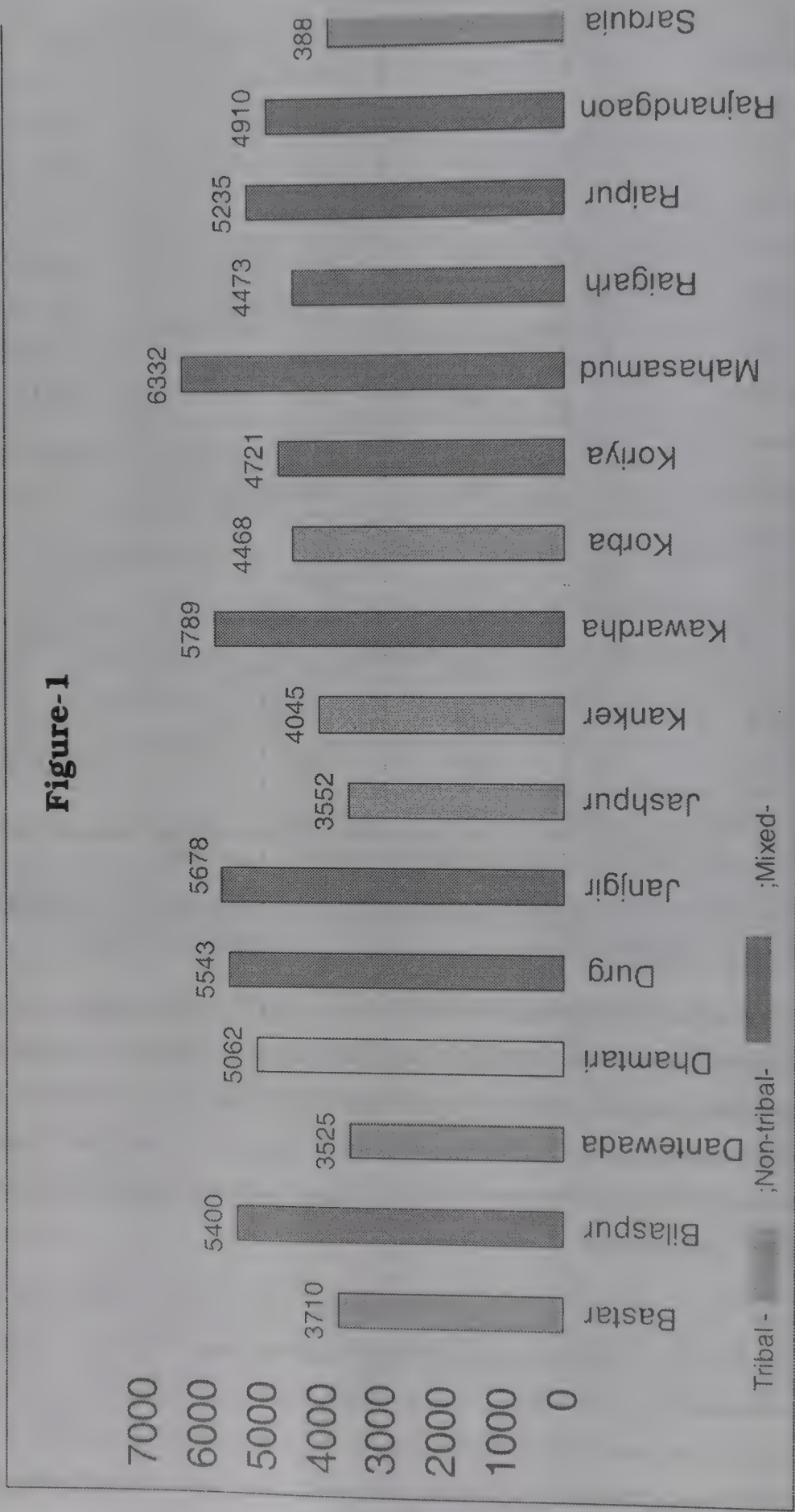
District	Popn. (2001)	Blocks	Subcenter	Av.Popn/subcentre	Tribal Status
Bastar	1302253	14	317	4108(3789)	Fully tribal
Bilaspur*	1993049	10	303	6577(5409)	Largely non- tribal
Dantewada	719096	11	204	3525	Fully tribal
Dhamtari	703569	4	139	5062	Mixed
Durg*	2801757	12	353	7937(5543)	Largely non tribal
Janjgir	1316140	09	211	6238(5678)	Non tribal
Jashpur	753096	8	212	3552	Fully tribal
Kanker	651333	7	161	4045	Fully tribal
Kawardha	584667	4	101	5789	Non-tribal
Korba*	1032432	5	195	5894(4468)	Fully tribal
Koriya	585455	5	124	4721	Non- tribal
Mahasamund	943527	05	149	6332	Non tribal
Raigarh	1265084	9	245	5164(4473)	Largely Non tribal
Raipur*	3009042	15	458	6569(5235)	Non tribal
Rajnandgaon*	1281811	9	214	5990(4910)	Largely non-tribal
Sarguja	1970661	19	507	3887	Fully tribal
Total	20913002	146	3893	5342	

Source : Secondary Data : Report from districts as available in directorate- June 2003.

Figure in bracket indicates ratio, after excluding major urban agglomerations: Durg 8.45; Bilaspur 3.54, Raipur 6.11; Rajnadgaon 2.02; Korba 1.61. Janjgir 1.18, Jagdalpur 1.08 Lakhs.

We can see that all tribal districts are well above the 3000 per sub-centre mark and all non tribal districts are well above the 5000 population mark. We, however, have to make some correction for large urban populations in Durg where the Bhilai steel city lies, in Raipur, in Bilaspur and in Rajanadgaon, Korba and Raigarh. Thus if we assume 6 lakhs for urban Raipur population then the ratio which in the above table is shown as 6569 falls to 5235 which is not as bad but still higher than norms.

In conclusion ,we find that sub centers number below the requisite norms, but on adjusting further for decadal increase of urban populations(since we have used only 1991 figures for urban population) , and also for the problems of lesser urban areas this deficit is not alarming. Their staffing and functionality, however, is another matter that we examine later. Also, we would later examine the question whether this norm is itself adequate.



SUB-CENTERS TO POPULATION RATIO FOR DISTRICTS
Source : Secondary data District Reports

DISTRIBUTION OF SUB CENTERS

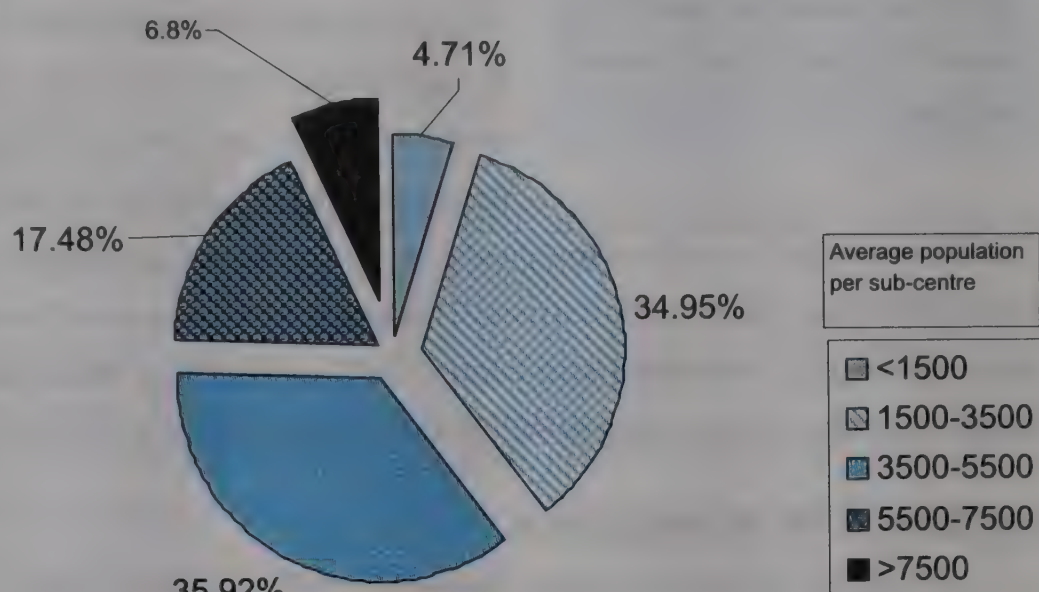
Our study (figure-2) data showed that the population allocation per sub-centre could be markedly skewed.

Secondary data also shows such a wide variation. We report below in Table-3 the figures from Bilaspur.

Out of 297 blocks, we do not have the population of 8 sections and their distribution is indicated in brackets in last column. This data is obtained from the districts report. Only three of the above blocks are declared

tribal – Marwahi, Gorella and Pendra. The large population per sub centers seen in the last

Figure 2: Subcentres grouped by Population coverage



Source : Primary data : SC facility survey.

Table-3 : Distribution of HSCs by Population per HSCs in each block of Bilaspur district

Name of Block	Total Sections	<1500	1500-2500	2500-3500	3500-4500	4500-5500	5500-7500	>7500
Bilha	39	11	8	7	6	3	1	3
Gorella	25	8	8	5	2			1 (1)
Kota	40	20	12	3	-			2 (3)
Lormi	37	20	10	4	-			2 (1)
Masturi	40	5	16	11	4		4	
Mungeli	26	16	5	1	1		1	1 (1)
Marwahi	29	17	8	3	1			
Pathaiya	20	12	6	1	1			
Pendra	18	9	6	1	-			1 (1)
Takhatpur	23	9	7	2	1		2	1 (1)
Totals	297	127	86	38	16	3	8	11 (8)

Source : Secondary data : District Reports

The lesson that we would like to draw is the limited gain made by further increasing sub-centers in a district like Bilaspur- unless such increase is focussed on the urban areas or where the concentration is well above norms!

column of table-3 are usually accounted for by being a town/urban area covered by a sub-centre. We, therefore, see that in terms of distribution, a majority of sub centers do not have a high population though urban areas do badly and there are odd pockets of such high population left. The low population per sub-centre are stated to be related to distance and the scatter of the population but there is little evidence to substantiate this. It is likely that a fair part of the skewed distribution is because of inadvertence and extraneous pressures. It may also be that by not disaggregating out the

urban population in calculating needs, we are providing adequate coverage to rural areas but under providing for the urban areas. The lesson that we would like to draw is the limited gain made by further increasing sub-centers in a district like Bilaspur- unless such increase is focussed on the urban areas or where the concentration is well above norms!

ADEQUACY OF WORKFORCE

There are 3800 sanctioned posts of MPW (F) and 3800 posts of MPW (M). Of these, 3657 MPW (F) and 1935(50.9%) MPW (M) have been filled up. In addition there are 1012 MPW (F) s under contractual appointment and a smaller number MPWs [exact number not available] under contractual appointment. We note that it is difficult to get reliable numbers even on such a basic and crucial aspect. is partly because all recent appointments are contractual and have been made at the district level . contractual employment of MPWs is enabled by the RCH plan, funded by the government of India and is being used to fill in the gaps where sub-centers are handling large populations. Thus, with the current strength of 4669 female multipurpose workers we should be nearer achieving norms for this cadre though the gap in the male cadre remains considerable. Even in these eight months of completing this study, contractual appointments have almost completely closed the gaps in MPW females.

The greater gap in the presence of male multipurpose workers also needs to be understood. The lack of institutions to train them is one of the main reasons for the gap. The lower priority to fill these vacancies, especially as they are part of the state budget is another reason. A perception of a lesser utility is another reason – but this is never stated explicitly.

PERFORMANCE OF FIELD FUNCTIONARIES AT SUB-CENTRE LEVEL

A. The Norms

The functions of the field functionaries at sub-centres, namely the female and male multipurpose workers, define the Subcentres' functions. The current task allocation of the multipurpose worker is given below (as per the govt of MP publication 1999)

Multipurpose Worker Female - List of tasks

RCH Programme

- ☐ Antenatal Care (ANC)
 - ◆ Registration of ante-natal cases.
 - ◆ Immunization of ANC i.e. Tetanus Toxoid and distribution of iron folic acid tablets with and encouraging pregnant women to take the tablets.
 - ◆ At least 3 checkups during ante-natal period.
 - ◆ Blood test for haemoglobin and urine test for all ANC cases.
 - ◆ Early detection and referrals of complications in pregnancy.
 - ◆ Scheduling of regular AN clinics and offer of help to LHV
 - ◆ Dietary advice to AN patients.
- ☐ Intrapartum and post partum care
 - ◆ Conduct normal delivery in sub centre/home and supervise normal delivery conducted by trained birth attendants at home.
 - ◆ Follow up of post partum patients and provide them health education.
 - ◆ Refer post partum cases with complication.
- ☐ Child care / Care of the new born
 - ◆ Weigh the neonate.
 - ◆ Refer the Low birth weight babies to doctor.
 - ◆ Encourage early exclusive breast feeding, especially of colostrum.
 - ◆ Start weaning after three to six months.
 - ◆ Train mother on how to take care if the baby has diarrhoea.
 - ◆ Immunize i.e. with BCG, Polio, DPT, Measles, and DT and also give vitamin A syrup at 9 months and every subsequent six months till three years of age.

Care In Diarrhoea

- ☐ Provide ORS & Refer when needed.
- ☐ Teach mother how to take care of the baby when baby has diarrhoea & how to use ORS

Respiratory Tract Infections

- ☐ To treat babies with minor or upper respiratory tract infection & Refer to Medical officer in severe infection.

Malnutrition

- ☐ To measure grade of malnutrition in children under 5 and provide iron and folic acid tabs.

- ☐ To refer the children with grade III & IV to medical officer.
- ☐ To provide Vitamin A syrup to all children.
- ☐ To educate and create awareness in community on how to provide proper nutrition food to children.

Family Welfare

- ☐ Refer MTP cases & follow-up such cases.
- ☐ Provide information to community regarding MTP.
- ☐ Advise on spacing to eligible couples, encourage them to use temporary, contraceptives like condoms, oral pills and CuT.
- ☐ Help to make arrangements to get tubectomy & vasectomy done for eligible couples & follow up of such cases.

Miscellaneous

- ☐ Detect cases of RTI among women & refer them to PHC.
- ☐ Detect cases of STD among women & refer them to PHC.

Training

- ☐ Help/Assist the medical officer & LHV in conducting training to trained birth attendant.
- ☐ Arrange meeting and provide information on various health issues to the women health groups.

Administration

- ☐ Maintain records of all the activities in the sub centres.
- ☐ Provide reports on regular schedule and keep record of work.
- ☐ Register marriages, pregnancies, births & deaths.
- ☐ Maintain general records.

First Aid

- ☐ Provide first aid in accident & in cases of medical and surgical emergency.
- ☐ Refer all complicated cases to MO.

Group Task

- ☐ To participate in monthly meeting and work in coordination with MPW male / TBA and LHV.
- ☐ To meet the LHV twice a week for obtaining guidance to attend the camps and special campaigns.
- ☐ To remain in regular contact with the adolescent girls & provide them sex education & family health.
- ☐ To conduct school Health Programmes.

Multipurpose Worker Male - List of tasks

The Male worker has all the work listed above as well. However, the notification talks of, assisting the ANM. The section on immunisation says

Immunisation

- ☐ To fix day, time & place for immunization.
- ☐ To keep in touch with the members / representatives of the community to provide help in immunization.
- ☐ To take help of TBA, anganwadi worker and members of the health community to bring children for immunization.
- ☐ To obtain vaccine from sector supervisor on stipulated date and time.
- ☐ To make sure that all the children under 5 are immunized.
- ☐ To make sure that children under 1 are immunized with BCG,DPT ,oral polio, measles and also get vitamin A in proper dose .
- ☐ To ensure TT immunization at the age of 10 & 16.
- ☐ To help supervisor (male) in immunization of school children.
- ☐ To help the MO, Supervisor in special immunization campaign.
- ☐ To conduct a follow up on second day of immunization & inform and refer to MO in case with complication.
- ☐ To help ANM in giving injection T.T to ANC Patients.

In addition, the MPW males' job list has the following :

Malaria

- ☐ To make slides for malarial parasites for all cases with fever & give them presumptive treatment.
- ☐ To provide specific treatment to all the malarial parasite +ve cases.
- ☐ To educate community on prevention of malaria.

School Health

- ☐ To help MO in health camps in schools.
- ☐ To give health education to school children regarding maintenance of personal cleanness.
- ☐ To help the health supervisor in immunization of school children.

Infectious disease

- ☐ To keep collecting information regarding cases of gastroenteritis, jaundice, measles, colitis, diarrhoea or any other infectious disease and on getting information from any

village inform health supervisor and take measures to prevent spread.

- ☐ To provide health education, regarding prevention of infectious disease.
- ☐ To disinfect well-water and other sources.
- ☐ To provide information, to the community on how to purify water. Regular surveillance of the areas from where people get drinking water i.e. river, pond and streams. Distribute and teach how to use chlorine tabs.
- ☐ To distribute and teach how to use ORS packets.

Evidently, the list is rather long.

The crucial question is, how much of these functions in practice are the MPWs able to perform satisfactorily? This is discussed in the following section.

Such long lists have many problems. Firstly, since no MPW can achieve all of it, few try. However every single one of the tasks listed above needs to be done if there must be an improvement in health status. What is the work done in practice depends only on what is monitored and that varies with which programme has attracted attention. Thus, if a pulse polio campaign were on, then in that week all other work would fade away. Secondly, such a long list leaves even the best worker vulnerable. Since no one's job is done anyone can be hauled up for disciplinary action or held responsible for one or other failure – which is a constant source of lack of security and motivation. Most important, it reflects a systemic failure in that a meaningful achievable list has not yet been formulated.

B. Utilisation of services

The proof of the pudding is in the eating! Let us first look at what the secondary data shows on the utilisation of various services delivered through MPWs at sub-centre level: (See Table-4).

The latest round of NFHS (1998-99) is a bit dated now but is still indicative of the situation regarding some key indicators of service delivery.

A comparison with primary data collected through our survey shows the following results:

Care in pregnancy

Data from 100 sub-centres show that 67 sub-centres do not conduct any delivery at all. Only 26 actually reported any delivery in the past year. The average number of deliveries

Table-4 : Service coverage situation – 1998-99

Item	Percentage
Percent of mothers who receive antenatal check up from any professional at any time	57.5
Antenatal check up in first trimester	26.7
Two or more Tetanus Toxoid injections	58.2
Iron and folic acid tablets or syrup	54.9
Assisted at birth	
• By TBA	42.7
• By ANM/LHV/nurse	9.7
• By doctor	22.3
Women who have heard of AIDS	19.6
Percent of children who receive	
• All vaccinations	21.8
• BCG	74.3
• Polio	57.1
• DPT-3 doses	40.9
• Measles	40.0
Percent of children with diarrhoea in the past two weeks who received ORS	29.7
Percent of children with ARI in the past two weeks taken to a health facility or provider	61.6

Source : NFHS II round (1998-99)

per month among these 26 sub-centres is only 1.8. These 26 sub-centers account for only 4.8% all registered cases in their areas.

In addition, a total of 31 cases who came at child birth in that month had sought assistance at delivery from the sub-centre and had to be referred to a higher centre for operational reasons(7) or due to medical reasons(24), an average of only another 2.8% per centre.

Thus, by their own report in just these 100 centers of an estimated 12824 pregnancies institutional delivery approximates 7.16% and ANM/LHV assisted home delivery another good 43.2 %. The number may be slightly higher as many cases go to district hospitals directly without referral but in percentages this would hardly make a significant change. The NFHS figure for assisted home delivery is 9.7%.

The number of pregnancy cases currently registered was placed at (100 sub-center respondents) a reasonable 12824 cases which for a population of 423839 is just what is expected. (There is the rule of thumb that for a population of 1000 population there would be 175 eligible couples and about 29 pregnancies. This is often used to calculate backwards from population figures to achievement figures by field staff since they know that their achievement is supervised on this ground). The coverage of pregnancies with Tetanus Toxoid is 87.2% and with iron and folic acid is 85.7%. These are relatively good figures but we note that these figures are obtained from the MPWs registers. Our discussions with MPWs on the field indicate that these figures are generous over-reporting. A comparison with NFHS data too indicates that this figure is much better. However, keeping in mind that we left out the centers where there are no MPWs posted, even methodologically we would be over reporting. The only lesson derivable is that if the MPWs are in place then such coverage figures are potentially attainable.

The situation is similar with family planning services. In the data collected from registers, we see that 105 couples per 1000 population registered which is 61.7% of what is expected by the rule of thumb. Of this 59.85% are reported as being protected- a figure known to be associated with various forms of over estimation. Thus A total of 36.06% all eligible couples are protected.

The quality of care is, however another issue Thus, for example of the 12834 ANM cases registered, only 295 reported having had a blood pressure check, which is one of the most basic of investigations. Also, it should be noted that almost none had haemoglobin estimation or urine test done.

Immunisation services

Immunisation services report over 100% coverage – 140%, to be exact for BCG if we assume that 2% of the population are below 1 year of age. Evidently, something is wrong with this figure!

Given the modest estimation of 21.8 % of coverage for all immunisation (as shown in NHFS –II) and of 74.3% coverage for BCG and 40% for measles, we are understandably worried about this “over achievement.” Even if we keep in mind that we have figures only from centers with female multipurpose workers, this cannot account for the overestimation. One problem seems to be that children immunized over the age of 1 are also included in this figure. Vaccine wastage due to having to open vials, when the number of children are inadequate for its full

usage, is often sought to be covered up (needlessly for such wastage to some extent is permissible). Obviously, this is an intensely monitored programme and the net result has been to constantly increase the figures on paper.

Malaria control

This is one major area of work. Some aspects like provisioning every village with chloroquine and ensuring prompt presumptive treatment is reported to have improved dramatically within the last two years. This change is difficult to quantify and we have not done it. Other areas like blood smear examination are improving but the changes are sub-critical. Thus, the slide collection in fever cases is significant – being over 46 slides per sub-centre in the last one month (the low malaria season) per sub-centre. However, though all collected slides were sent for reporting, only 16 per sub-centre (35%) on an average came back reported after two weeks to a month (of which 1.8% came reported positive- not unexpected for the month when malaria is the lowest). In times of high ‘fever incidence’ the ability to report and send back reports in time would only go down further as the volume of work increases.

Not much time is reported as spent on other areas of malaria prevention by the sub-centre staff – either in the form of health education or in the form of spraying or in any form of vector control.

TB and leprosy

The number of reported registered active cases of TB is 148 from 42 centers (another 28 sub-centres have reported nil) with an average of 3.52 per centre. In the case of leprosy, there are 308 from 53 reporting centers (another 17 centres reported nil) with an average of 5.83 per centre. These are useful benchmark figures to have as the RNTCP and Mitadin programme both start up. They show very modest levels of case detection.

Since case detection of tuberculosis depends on both adequacy of outpatient attendance and quality of care (being able to suspect tuberculosis and test for it in a chest symptomatic reporting voluntarily to the health system), case detection figures, reflect directly on utilization.

Curative care for simple illness

This is a small but significant area of their work. Almost all the sub-centres interviewed reported visits for minor illness and during visits to these sub-centres one would often witness persons coming in for tablets. The average cases seen per sub-centre are about 130 cases per

month and its distribution is as shown in table - 5.

Table-5. : Curative Care in Health Sub-centre

Disease	Cases seen Per sub-centre per month
Follow up pt of TB-Currently	2.1
Follow up pt of Leprosy-Currently	4.4
Fever	22.2
Pain without-Fever	8.46
Diarrhoea	4.66
CVS disease	4.42
Neurological	7.55
Gastro-intestinal complaint	8.28
Antenatal	28.8
Post natal	22.25
Gynaecological	3.24
Eye	3.97
Ear nose Throat	1.41
Skin	2.71
Psychiatric	0.64
Minor Injuries	3.22
Major Injuries	0.18
Surgical Minors	0
Surgical Major	0
Dental	1.54
Others	1.32
Total	130.03

Source : Primary Data: HSC facility survey.

This figure - 130 includes 50 cases of pregnancy per month. Excluding that we get 80 cases of symptomatic treatment per month or about 2.5 cases per day including all fevers (which the MPW is required to see under the malaria programme) and diarrhoeas and respiratory infections and minor gynaecological problems which all fall under current work description. We note that this figure for the number of cases for curative care may be under-reporting as records on this non monitored aspect are weak. Looking at stock movement of drugs and her reports, we can say that the figure could be higher. The only lesson we draw is that first contact curative care in a wide range of illness does take place despite all the constraints, though at very modest levels. A higher level of utilization of her services for this dimension would give more access and support in the community and this needs to be planned for.

In what follows, we shall highlight specific constraints that have affected

the provision of services by field functionaries at sub-centre level. These are illustrated with data collected through our primary survey.

In summary, the registration of pregnancy happens adequately, though antenatal care is limited to distribution of iron tablets and tetanus immunisation. Immunisation of infants is also a major activity. Assistance at delivery is extremely low and all other aspects of child care almost not on the agenda. Symptomatic curative care occurs but at low levels. In the male workers job description only slide making for malaria and curative care predominates.

CONSTRAINTS ON SERVICE PROVISION

Geographical

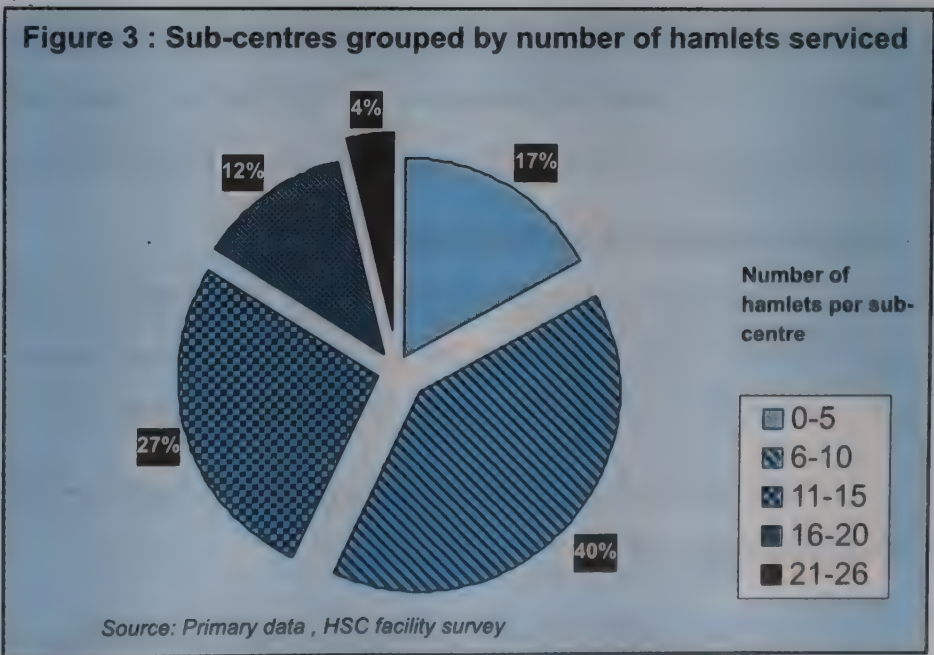
Dispersion of the population in numerous hamlets is a major problem in providing services. Thus in the 105 sub-centers studied, the average number of villages per sub-centre was 3.9 and the average number of hamlets was as high as 10.1 per sub-centre. This is shown in figure-3.

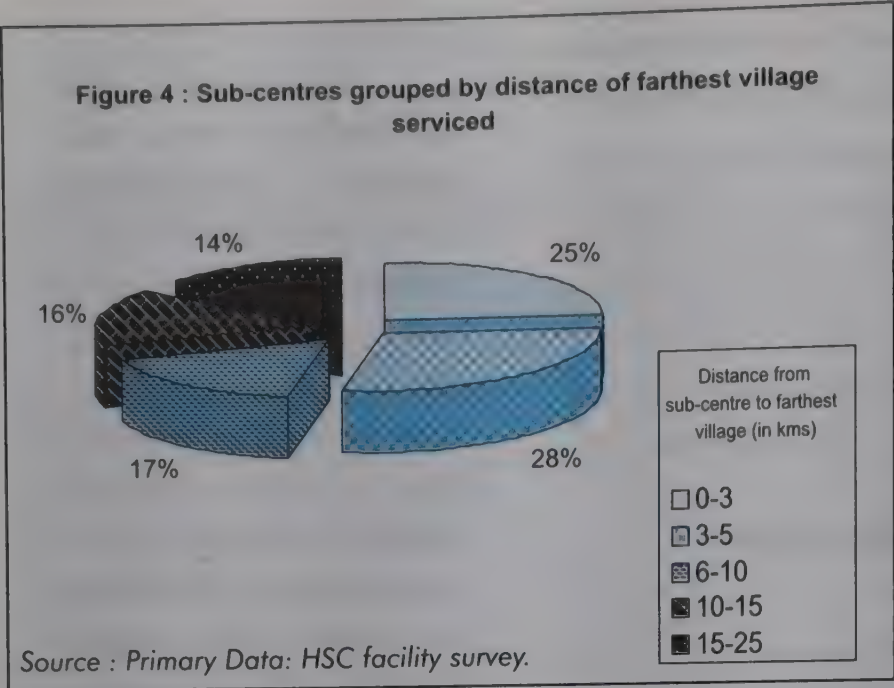
The geographical dispersion of the hamlets is also considerable: If we consider a 5 km distance as manageable then we would see that 30 of these sub-centers have hamlets beyond 10 kms as shown in figure-4.

The dispersion of the population makes outreach a very difficult task. Further, most of the hamlets have no motorable roads and various natural obstacles also have to be faced.

In tribal areas many sub-centers reported unsuitable intra- village and inter-village location. The tribal project and

In summary, the registration of pregnancy happens adequately, though antenatal care is limited to distribution of iron tablets and tetanus immunisation. Immunisation of infants is also a major activity. Assistance at delivery is extremely low and all other aspects of child care almost not on the agenda. Symptomatic curative care occurs but at low levels. In the male workers job description only slide making for malaria and curative care predominates.





its engineers, in response to a request from a panchayat leader, would often make the choice of the location of the sub-centre building with the backing of a senior politician. The building would have been constructed before it was notified to the block medical officer in charge. Sometimes a building could be sanctioned and built in a section, which already has a sub-centre building when

at the same time so many sub-centers have no building!!

The choice of location of building within a village is also arbitrary and largely dependent on where land is made available free- a condition of undertaking construction- rather than on where access is maximal.

Road access and distance from other sub-centers are also important. However, since locations of many sub-centres are request-driven and the person making the request ,and the authorities granting it have only a limited set of priorities in mind and even less data, the consequent location is more often than not, sub-optimal.

Also one of the most frequently raised problems in focal group discussions with local people are the wrong attachment of a village to a sub centre or PHC. Often there is a sub-centre nearer, but they have to travel longer to their earmarked sub-centre.

Linkage to primary health centre

The primary health centre is the immediate referral linkage for the sub-centre. The supervisors of the sub-centre are located there (except when the sector has no PHC) the supplies are procured from there, and work reports are given there.

The problems of access between PHC and the sub-centre are therefore vital this is shown in figure-5.

Of the sub-centers for which this data is available, 56.38% did not even have a motorable road. Of those with motorable roads 80% had public transport available.

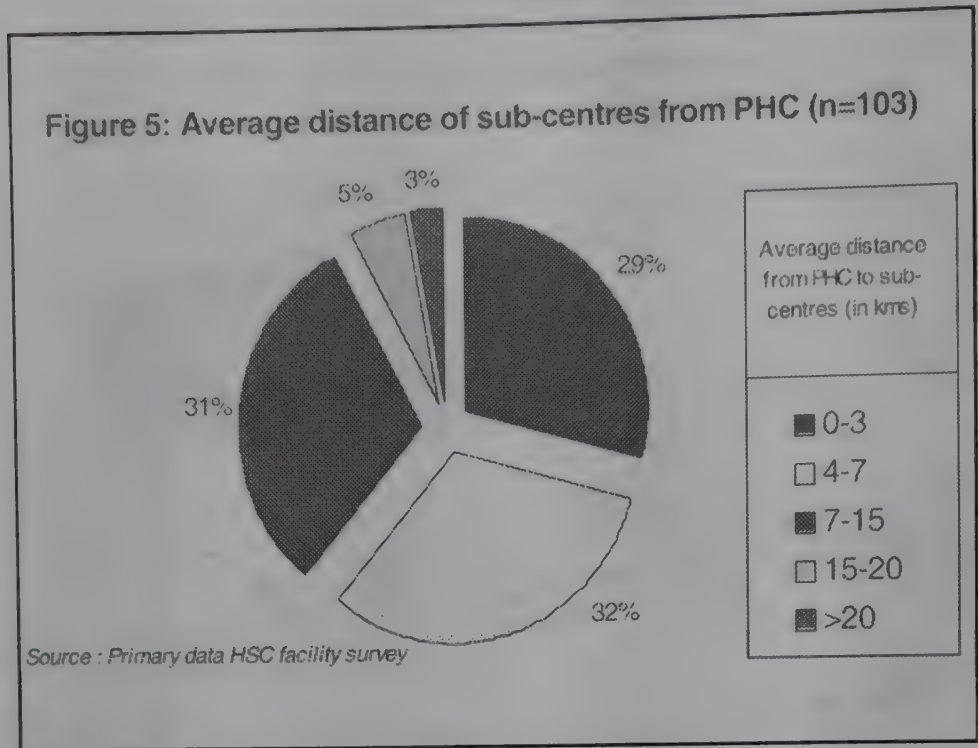
A typical example of geographical dispersion
Sector Raghunathnagar

सबसेन्टर : सरना
सी.एच.सी. : बाड़फनगर
जिला : सरगुजा

पण्डरी, देवा पाटा (105)
3 K.M.
अरना (705)
1/2 K.M.
उमरपाटा (100)
2 K.M.
बहुसाई पाटा (160)
1 K.M.
हरिजन पाटा (100)
3 K.M.
नरली पाटा (100)
4 K.M.
मुण्डा पाटा (105)
2 K.M.
हरिजन पाटा (200)
1/2 K.M.
कुम्हार पाटा (100)
1/2 K.M.
देवदिया पाटा (100)
1/2 K.M.
देवदिया (100)
1/2 K.M.
सोता बडुआ (100)

संकेत
+ सब सेन्टर (Sub-Centre)
▲ गांव (Village)
■ मोहल्ला, पाटा, टोला (Hamlet)
---- जनसंख्या (Population)

[illegible]



If we include those villages which had no roads but one could access public transport after walking some distance, the number rose to 70% (and 75.53% if shared jeeps were also included). Frequency and timing of buses could be grossly inadequate making actual access much less. Further 17 sub-centres reported seasonal rivers, which often cut off access, and 4 reported unsafe forests

making access more difficult. These sub-centres would, therefore, be less occupied by staff and less supported and monitored.

Adequacy of Infrastructure

Out of the sub-centres sampled 41% were housed in government buildings, 4.76% had shared building with panchayat; while 18% had rented building, and 36.19% reported no building at all. The government’s annual report for 2002-2003, records that overall for the state, 1458 out of 3818 sanctioned SCs or 38.19% of sub-centres have a government building.

Government buildings usually had five rooms- an outpatient room of about 8ft square, a hall of about 22ft x 8ft used for conducting deliveries and labour, two rooms of about 8ft square for residential purposes, a store- often used as kitchen and two small toilets and two verandas (of about 700 sq.ft.) one of which functions as a waiting room for patients. Whereas in rented buildings, it was usually a single room of about 100 to 150 sq ft ,with little other facilities. In other cases, the stores were kept in the ANM’s own accommodation, for which also the government paid no rent.

57% of govt buildings were rated as being in good condition, about 26% fair and the rest poor. In contrast, in rental buildings only about 30% were rated to be in good condition and an equal amount rated fair – the rest being perceived as poor condition.

Certain obvious conclusions emerge from this figure. Firstly, institutional delivery at the sub-centre is ruled out on this count alone as in 60% of sub-centers there is not enough space. Secondly, even the function of the immunisation day and providing curative care is hampered because the MPW (F) finds it extremely difficult to achieve this if the single room available is also her home. And the problem of having the stores in ones house and the resulting demoralisation due to lack of this basic facility have all to be taken into account. In such situations the female MPW usually uses a panchayat building or school or any other government building as the venue for her services, but there are places where even none of this is available. Obviously, the inter-sectoral coordination to find the funds needed and to prioritise villages for the construction of buildings according to needs have not been adequate.

Other Infrastructure supplies

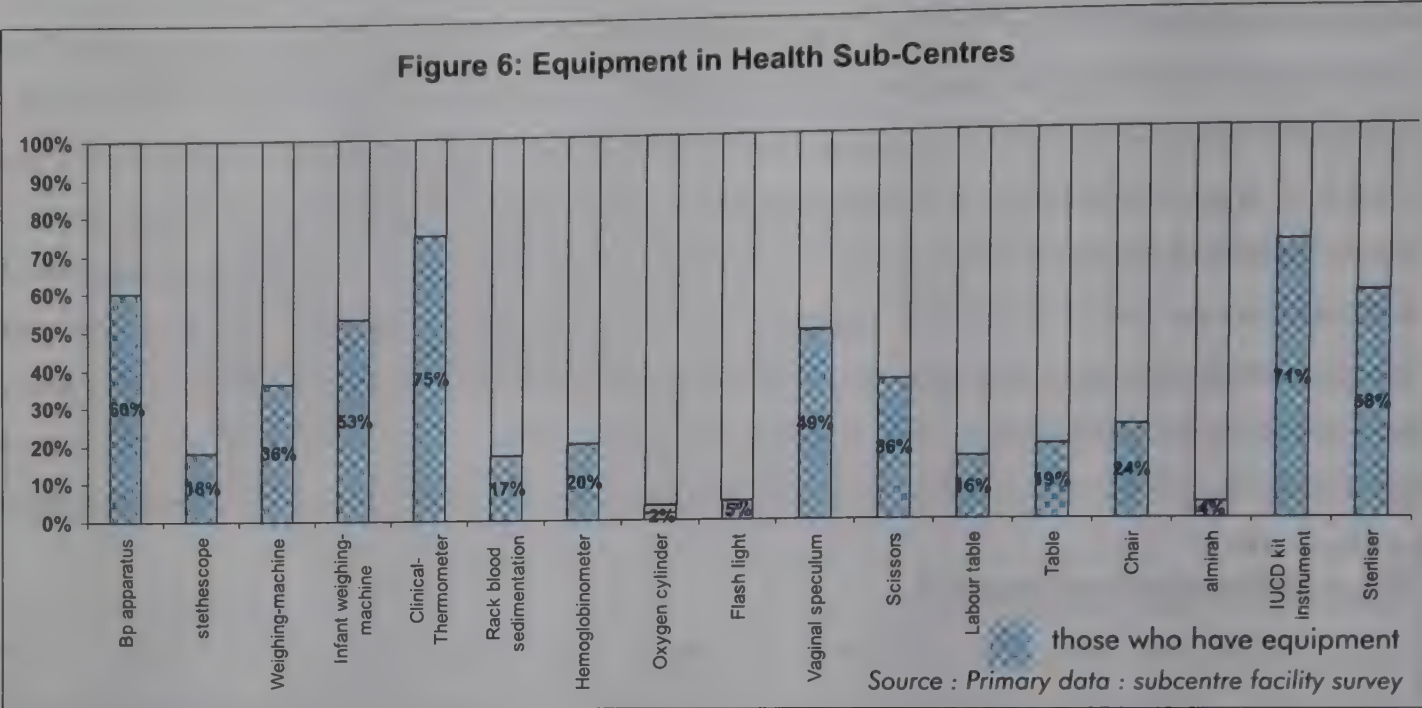
Other infrastructure supplies like water and power, relate to the quality of the sub-centre. In places with government building, most have adequate water supply. But one fifth report some problems, which are large enough to compromise the quality of service. These gaps need local solutions. As such, the system in place is neither able to take note of such gaps periodically nor able to respond to the needs adequately. At present any such gap is notified via the BMO to the chief medical officer who forwards the request to the state directorate where it is to be sanctioned. The funds earmarked for this to each district are not known at the year's beginning. There is no set procedure, which takes care of such gaps.

Adequacy of Equipment in sub centers

The response of 102 sub-centres with regard to adequacy of equipment is given in figure-6.

The serious lack of equipment needs to be noted. Most of it relates to sub-centres where there are no buildings, especially those where MPWs are operating from their residence.

We note that often the sub-centre staff was not aware of some of the equipment like the hemoglobinometer. Even if these pieces of equipment were available, many of them had never been unpacked and used. We should also note that several of the staff was not aware of even the need for such equipment. Thus 75% had a clinical thermometer and all those who did not have it, asked for it. (The questionnaire had a column asking whether this equipment was required and if so how many.) Some needed more than one thermometer available in the centre- given the fact that there are two staff. This was also true for BP apparatus, IUCD kits



and furniture but when it comes to hemoglobinometers only 20% had it and only 35% more thought it necessary to have one. About half did not even consider it as needed. (The actual figure of equipments available may be under-reported as some of them are not even aware that they had the equipment.)

Many sub-centers, mostly those housed in rental buildings and panchayat buildings did not have any space within which the equipment could be kept open and ready for use.

Another category of “equipment” is furniture and almirahs. At one level, these are trivial problems to handle. But at another level many problems arise because these are not attended to in a timely manner. Again, the key is improving on current systems so that they can be regularly attended to.

Except for the furniture almost all the other equipment is inadequately utilised. There are many reasons for this:

- ❑ Incompleteness of equipment – It is not possible for taking blood pressure meaningfully without a stethoscope. Palpatory BP readings are incomplete (it leaves out the more important diastolic pressure measurement) and unreliable as compared to the auscultatory measurement. Here the failure seems to be reluctance to accord the MPW with a stethoscope- symbol of the profession - by a medical system. Again hemoglobinometers lack concomitant supplies of acid

reagent needed to do the test.

- ❑ Lack of training is another reason stated. This may be applicable to equipment like the IUCD kit and the vaginal speculum.
- ❑ Lack of monitoring and motivation is another factor. Tasks requiring such equipment are not perceived as important unlike tasks like immunisation and registration of pregnancy. Thus most antenatal care focuses on registering pregnancies – not on examining them. Thus taking blood pressure – a cardinal part of antenatal care hardly ever happens- even if the equipment is available.

Adequacy of Drugs and Supplies

The range of drugs is limited but drugs in the national programmes seem to be available adequately. The multipurpose workers' own perception is that the drug supply is adequate. However, the population does not see her as a source of basic curative care and her utilisation on this count is low- less than 80 cases a month or about 2 to 3 cases a day. The main source of supply of drugs is the ANM drug kit supplied by the central government. The recommended expanded list of drugs for ANMs is not known to almost any ANM. The current list of drugs with the ANM is very limited and would leave out many common ailments. Thus the table-6 shows that whereas ORS, Vitamin A, Iron and chloroquine had a good availability- this dropped sharply when it came to antibiotics, antipyretics. It dropped even further when it came to antispasmodics or anti allergy medication which are needed for the MPW were not part of the

Table-6 : Drugs Availability in Subcentres.

Drug	Availability (% of HSCs who said it is available currently)	Regular (% of HSCs who said it is available who also said supply is regular)
ORS- 100	99	93
Antipyretic -99	68	55
Antibiotics	67	54
Anti TB	36	32
Anti leprosy	82	71
Malaria	91	81
Anti -Spasmodics	52	45
Anti allergy	36	33
Anti -Worms	73	60
Iron	94	81
Vitamin A	95	85
Contraceptives	68	62

Source : Primary data : subcentre facility survey

central ANM kit. We also note with concern that certain drugs with high need like anti tuberculosis drugs, contraceptives, de-worming tablets are also not uniformly available.

Training of MPWs (Female)

Another major reason for poor performance of the sub-centre relates to the multipurpose workers' skills. These skills are inadequate – by everyone's estimation - the director's, the district and block officials', and by the workers themselves. Thus, in one block, in a group of 23 ANMs discussed with, only 10 had the skills and confidence to do IUCD insertion. In one discussion with MPWs during a field visit even the dose of choloroquine (a sort of base line question for the system) could not be answered correctly.

The study therefore gathered a brief data on her training experience to quantify this. This is shown in table-7.

We may also note that of these trainings only the RCH and CSSM trainings had 12 to 15 day durations. IPP-6

Table-7 :Total Trainings received in 93 MPW Females interviewed :

	Number of MPW(F) trainings since 2000	Number of MPW(F) trainings in 1994 - 2000	Number of MPW(F) trainings since 1984 - 1994
RCH	19	47	2
IPP-6	3	26	6
TB	15	-	-
Leprosy	13	-	-
CSSM	-	23	3
Malaria	5	3	2
Polio	5	1	
Mitanin	4		

Source : Primary data O&M survey MPW(F).

was six days training. For the other programmes the training was invariably 1 or 2 days – more in the nature of a brief sensitisation rather than any serious training. The Mitanin programme training was an exception in this regard – it was for six days, and was on “understanding the

community”.

But these trainings had not been evenly distributed amongst the ANMs. A few ANMs had received five trainings in one case within two years while many had received no training at all. Table - 8 gives us an idea of the skew.

This training pattern is grossly inadequate. There are no regular refresher courses for

MPWs. There are many other tasks – like curative care for which they get no inputs at all. Also some skills like basic laboratory work (h a e m o g l o b i n estimation for example)

Table-8 : Training distribution amongst MPW(F)s

Item	% of MPW(F)s interviewed
MPW(F) who received no training at all in last 3.5 yrs	48.39
Who received no training more than three days in last 3.5 yrs.	86.02
Who received no training in last 10 yrs	21.51
No training at all	7.53

Source : Primary data O&M survey MPW (F).

go into disuse if there is a long break in doing the tests (due to lack of equipment). These need to be revived through training. Aspects like social mobilisation, community participation, village level action planning, communication skills and IEC also need systematic training inputs. Frequently changing national programme guidelines also make frequent reorientation necessary.

Over 20 MPWs (F) were interviewed in-depth over these 6 months. Again and again the lack of skills and knowledge on many basic areas were apparent, and again & again this was one of their must frequently articulated requirements.

In a focus group discussion held with 20 MPW (F) drawn from all over the state in Bilaspur, skills in curative care emerged as one of the most important perceived areas where training was needed.

The marked unevenness in the extent of training received and the inter-training duration also need to be addressed.

Training for MPW (Males)

The training situation for MPW (M) is similar to that of MPW (F).

Though there has been some attempts to train MPW(M) as laboratory technicians, no one performed that function in most of the centres we visited. Most MPW(M) also think it unnecessary to get training in RCH because it was assumed to be the function of female workers! In the

Table-9 : Training in MPW (M)

	% of MPW(M) interviewed
MPW(M) who received no training in last 3 yrs	68.66
No training in last 10 yrs	17.91
No training at all	8.96
No training of more than 3 days duration in last three years	77.61

Source : Primary data O&M survey MPW (M).

Table-10 : Training in MPW (M)

	Number of MPW (M) trained since 2000	Number of MPW (M) trained in 1994 - 2000	Number of MPW (M) trained in 1984 - 1994
Microscopy	5	1	10
Malaria	5	-	4
Leprosy	10	1	-
RCH/CSSM	3	33	9
TB	13	-	-
IPP	3	16	3
Pulse Polio	3	-	-
School health	2	16	-
Mitanin	1	-	-
Paramedical?	2	-	-
ECG/ICCU	1	-	-

Source : Primary data O & M survey MPW (M)

n a t i o n a l
programmes the
trainings are
usually of one or
two days, which is
useful as
sensitisation but
would have a
smaller role in
b u i l d i n g
capabilities. The
pattern of training
programmes that
the male worker
has had is given in
table-10.

One specific reason why the concern about lack of training is much more with this category is that a good number of them did not have the basic 18-month training course that is mandatory for recruiting a female worker. Many of those currently working as MPWs functioned as vaccinators or malaria workers or leprosy workers etc.

This is even truer of supervisors for this cadre – where the majority of them did not join as multipurpose workers but were subsequently absorbed in this category during the policy shifts when uni-purpose workers were made multipurpose workers. This shift continues to this day. The latest in this is the NMAs who are being absorbed as Health supervisor males – against without any training adequate for this purpose.

As a result of these factors, knowledge and skill levels of MPWs males and supervisors as contrasted to MPW (F) can be very low. Repeatedly in interviews, the male workers could not state the correct chloroquine dosage for adults. Many other knowledge dimensions are equally low. If we add to this the observation that many of these very categories of staff are active in the informal provision of curative care services – often for a fee and often irrational over medication type care – then the problem of this lack of knowledge becomes even larger. All these aspects need to be addressed urgently.

SERVICE CONDITIONS FOR MULTIPURPOSE HEALTH WORKERS

Transfer policy for MPWs- females and males

One of the repeated problems expressed by MPW (F)s especially those posted in remote areas, was the issue of transfer. They repeatedly asked as to why postings were so discriminatory with those having influence able to enjoy plum postings life long while others had to suffer in remote areas. The perceived discriminatory nature and unfairness of the way in which transfers were organised is one of the most important reasons for not being able to mobilise staff for rural areas. There is currently no transfer policy in place.

Our data in table-11 and figure-7 shows that most MPWs (F) have not had a transfer in

Table –11 : Transfer experience of MPW

	Number of MPW (F) n=94	Number of MPW(M) n=79
Those who report transfer	35 (37.23%)	42 (53.16%)
Of whom those who report : Transfer after 30 yrs	1	-
Transfer after 20 yrs	2	-
Transfer after 10 yrs	9	6
Transfer after 5 yrs	9	7
Transfer in 0 to 5 yrs	14	27
Those who report no transfer		
Who have been in service for	N=59(62.76%)	N=37 (46.84%)
30 yrs	1	2
20yrs – 30 yrs	5	7
10 –20	21	9
5- 10	6	8
0- 5	13	11

Source: Primary data O&M survey MPW

a long time. Though this may be welcome to a few who have been able to settle with families- it certainly if not fair or satisfactory to those who are working in remote areas.

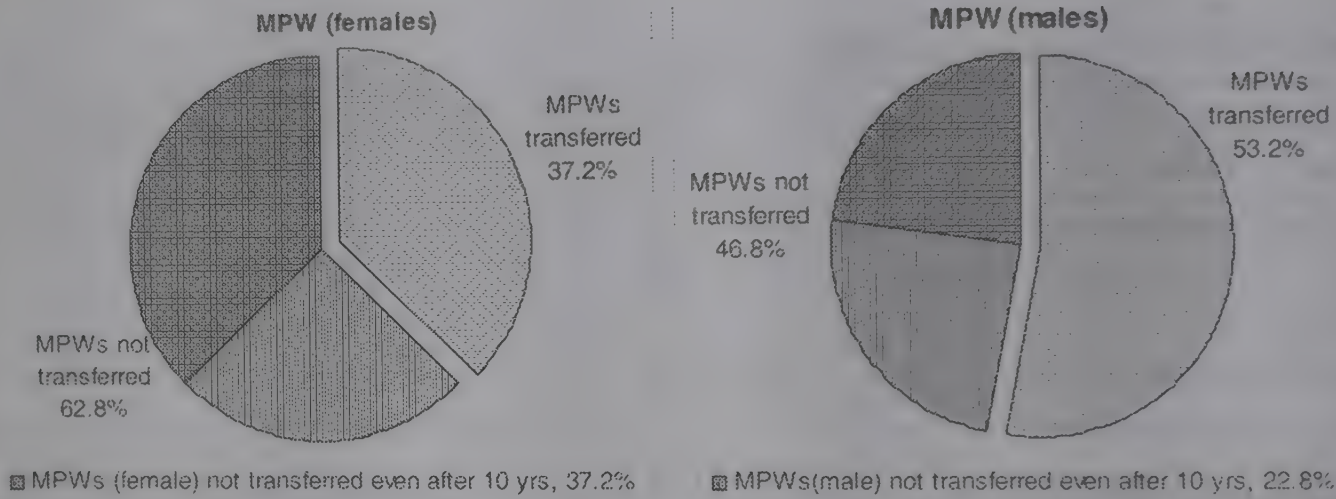
We also note the high levels of separation from families that ANMs have to face and note with concern the impact that this must have on morale and motivation and a sense of security. Many have tried for transfers and given up trying but harbour such resentment

against the government on this count that motivation will not be available.

Transfers seen to be granted depending on the ability of the person seeking transfer to reach out and influence decision making in this regard. The fact that some can use their influence and others cannot is also a further reason for a feeling of injustice.

The experience of MPW males shows that transfers are more frequent in this cadre.

FIGURE - 7 : TRANSFER EXPERIENCE OF MPWs



Source: Primary data O&M survey MPW

This is also because they have seen greater shifts in job allocation in their service period – many of them having started as uni-purpose workers. However as with the female multipurpose worker, there is no regular transfer policy and many get difficult postings from where they cannot shift. This leads to a loss of morale.

Promotion Policy

The only promotion available to MPW (F) is to LHV post (also known as health supervisor or sector supervisor -female). Though eligible for promotion after ten years they may in fact never get promotion at all – or it comes too late. The promotion takes the form of being allowed to undergo a six month training programme for LHV, after which the final appointment as LHV may take an indefinite time. The lack of promotion and indeed any sort of career plan or possible ambition is another reason for lack of motivation.

For MPW (M) the promotion is to the post of Sector Supervisor male or Health Assistant as it is called. This promotion unlike for the LHV does not require training. Here, chances of promotion have become minimal because of so much absorption of cadre from other categories. Again, there is no career plan possible at present for this category too.

Adequacy of accommodation

Any government built sub-centre also provides accommodation for the female MPW. Where the sub-centre is rented, the rent is usually paid by the female MPW as for her residence. And therefore it functions as her residence only. The percentages for this were discussed earlier.

Providing accommodation for male multipurpose workers is generally not even aimed for. There seems to be no real reason for this except the general perception of their services as less valuable. But this reason is self-fulfilling. Thus only one of the 79 MPWs (M) interviewed reported availing of government accommodation.

Support to the multipurpose workers

Panchayats

Another interesting finding is that panchayats are perceived as helpful by a majority of MPWs in contrast to what is often reported in group discussions. Staff perceptions of panchayats as uncooperative, as expressed in focal group discussions, are not supported by this data collected from them. Of course there is a large segment of panchayats which are not cooperative, and in a discussion highlighting constraints, these are likely to be expressed more. The insistence on a mandatory signature by the sarpanch before the MPW (F) collects her wages is a little liked and problematic provision. Even this is not resented by 64%.

Community Support

The community also appears willing to accept services again going against the perception of poor community awareness and acceptance as often emerges in group discussions.

Table-12 : Panchayats: Response from 200 MPWs

	Yes
Do panchayats help you	62%
Do women in panchayat help you	75%
Do you attend panchayat meeting	80%
Does mandatory signature in panchayat help.	64%

Source : Primary data O&M survey MPW.

Table-13 : Perceived community acceptance of services

	Very willing	willing	Less willing	Not willing
Care in pregnancy	51%	31%	15%	2%
Iron and folic acid tablets	full compliance	incomplete compliance	non compliance	refusal of medication
	69%	15%	15%	1%-

Source: Primary data O&M survey MPW.

One of the most common reasons quoted for non – utilization of services is ignorance or lack of motivation. In most instances where we have data, this has not been established. Our study had two questions related to care in pregnancy and in both, the persons who were not willing or not accepting accounted for 2% and 1% respectively while those accepting but not complying was still a small 15% only. Our decision to focus only on supply factors vis a vis utilization seems justified!!

Personal Security

A major issue that emerged very powerfully in both individual interviews and in Focal group discussions with female MPWs is security. In the structured interview 12% said that they faced harassment often and 5% chose to remain silent. To another question 11 % answered affirmatively to facing violence often with 11% choosing not to answer-about 22% in all with 11% affirming frequent violence. This is for any occupation a very high figure.

The contrast in this situation to males is striking. Only a modest 3% of males reported any experience of violence or threat to violence, with no non-responders. Those having to face insults/humiliation were 5.04 %.

The department has not addressed personal security of female staff as an issue, and unions have not known how to take this up. This violence certainly affects the morale of the female staff, and their sense of dignity about the job and therefore their performance. Male staff do not recognise that their counter-parts face it. In focal group discussions that were gender-mixed, even when women insisted that there were problems of harassment or violence, men would at best fall silent rather than agree.

The nature of violence was not quantified, as it was not considered possible to do so within the ambit of this study. However, discussions invariably agreed that sexual harassment formed a significant part of it and sexual violence was not unknown.

Support from senior officers and the establishment

Here there is wide divergence between the questionnaire-based data and the interview based data. In the questionnaire based data 96% of the respondents answered affirmatively and only four % remained silent. On the other hand in all focal discussions and interviews the lack of support from superiors emerged as one of the major problems. There was lack of training support with little or no on-the-job training provided by the supervisors. Equally important is that when there were problems with the community, the medical officer or superior would seldom intervene to help. Travel allowances etc were seldom paid on time and there were reductions in these, which were perceived as unfair. Perhaps the respondents did not want to state in writing that there were problems from the lack of support of senior staff- or perhaps the lack of support was not serious enough to merit concern. Nevertheless, as a general principle – support instead of supervision should be the central role of all supervisors to any category of health workers who work in such admittedly difficult conditions.

Purchase of registers and out of pocket expenses

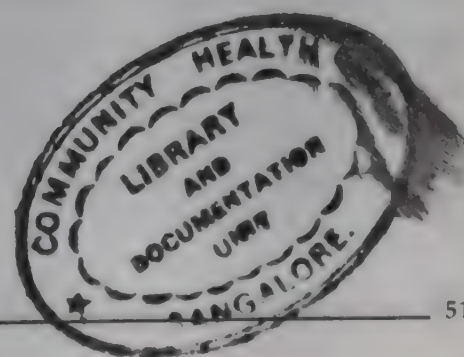
Another significant cause of disaffection amongst multipurpose workers is the expenses they make for the purchase of registers and on touring their areas. To a multipurpose worker already burdened with maintaining such a large set of registers, this acts as an attitudinal last straw.

Table-14 : Expenditure burden in Rupees.(annual)

	< 250	250- 500	500- 1000	>1000
On tour female MPW(n=93)	47.31%	44.0	8.5%	01
On tour males MPWs	42.56%	55.0	3.0	.
On stationary female MPWs	95%	05%	-	-

Source : Primary data O&M survey MPWs.

There is also the related report of not getting full travel allowances for many jobs but having to sign for vouchers showing higher amounts than what she has received. Even more than the economic hardship that this causes, in terms of the motivation and accountability such practices can be damaging.



Perception of tasks by MPWs

We looked at what tasks are seen as important by MPWs.

We can see that there is broad co-relation between their extent of achievement on various programmes and their perception of priorities. Immunisation is perceived as the major priority of MPW (F) and this matches with the reported outcome, which is best in immunisation.

Family planning is the next major priority but here achievements are more modest, even by state's reports and by what reports this study has gathered- though both are quite susceptible to over reporting. Obviously, acceptance issues and issues of service delivery mechanisms need to be addressed.

Care in pregnancy is the second item ranked as their first priority and the third most

Table-15 : Frequency chart of perceived job responsibility of 86 MPW (F)

Job Responsibility	MPW(F)s ranking of jobs in perceived priority order	MPW(M)s ranking order of jobs	% of MPW(F)s who said this was their Priority 1	% of MPW(M)s who said this was their Priority 1
Immunisation	1	5	34	10
Family planning	2	6	4	10
RCH	9	7	15	5
Care in pregnancy	3	12	17	5
Health education	7	4	5	15
Curative care	11	3	4	7
National Programmes	4	1	4	15
Malaria	5	2	2	15
Leprosy	6	8	2	5
Blindness	10	10	0	5
Epidemics	8	9	0	0
Registration	4	11	6	0
General	9	4	8	10

Source : Primary data O&M survey MPWs.

cited task allocation. Achievement estimates for this vary widely between sources. One reason for this seems to be in the perception of what is antenatal care. In fact, most MPWs referred to it as pregnancy registration or as undifferentiated from registration and for them this constitutes

the single most important aspect, followed by tetanus immunisation and iron and folic acid tablet distribution. All other aspects of antenatal care were much lower priorities for many.

Curative Care in sickness is one aspect to which almost all of them contribute significantly too. However, it does not show up in either perception of importance, or training programmes or even on monitored activity. That curative care is happening is not surprising considering that they are one of the few sources of medical help available in many rural areas. What is surprising is that its importance has been so under-recognised within the system.

For male MPWs the commonest responses were 'National programmes' and 'malaria'. The response 'national programme' usually also meant malaria along with to a lesser degree, leprosy and blindness. RCH too is a national programme but the way the term national programme is used seems to exclude this. The next common response was health education. What this meant in practical terms could vary widely as our case study shows.

ORGANISATION OF WORK

Other than looking at such disaggregated determinations of sub-centre motivation and functioning we also need to take into consideration the overall organisation of work elements in relation to the staff available.

There is a need to optimise the functions assigned to the MPW – so that they are feasible, so that they have sufficient quality and so that they may be supervised adequately, so that they are able to provide satisfaction to the community and so that they are effective on key health indicators. Hence decided to do a workload analysis of the MPWs.

The Workload Analysis Study Data

□ Female Multipurpose Workers

We studied the working pattern of ANMs over the previous work. Investigators were asked to make the ANM recall her last seven days of work and by averaging this across the sub-centres, we could ascertain what was broadly her time spent on various activities. We got reports from 80 centers, which were judged of sufficient quality to use for this analysis.

From this we find that- on an average the following pattern of work - the ANM spends one day in her head quarters (usually a Tuesday) and one day reporting to her supervisors (usually a Saturday) at the sector. Yet another day goes to some camp – like LTT camp and on two days per week she makes a visit to one village – and within that village -one or two hamlets. Thus usually two days per week is the maximum time she would have per week in visiting

houses. Where there is sector level activity or some more intensive ongoing, campaign her village visits drop further and this is reported to happen in at least two weeks of every month.

Matching this with her work allocation, we can immediately see the following problems. At best she visits 8 hamlets per month, whereas in theory she visits every one of her 10 to 15 hamlets once every two weeks. Posted in a remote area, often separated from the family, the requirement of leave is also important. Even if she stays with her family, the need to attend to her family reduces the likelihood of more days for tour.

Only on one day in the week is she available at her sub-centre. So her availability for performing deliveries is low. If she stays at the HSC she can conduct deliveries at the night- but given transport problems pregnant women in labour are unlikely to come at night.

With two days of village visiting, she cannot reach every doorstep of her approximately 700 to 1000 households once every two weeks. That makes it difficult, indeed impossible, to provide services like prompt diarrhoeal disease care, prompt identification of childhood pneumonia, or blood smear examination and presumptive malaria treatment on the first day of fever itself. Indeed all those services that need her to be there within a day of the event occurrence.

This understanding is not reflected in her supervision. An ANM – and not the male worker usually is often suspended when there is a disease outbreak, which she has not noticed. But even theoretically it is not possible for her to know this. If she visits hamlets by bus the contact time with the village before the last bus back is so short that the visit is often cursory. The same would hold for whenever there is a long walk needed to the village- for she would seek to get back to her home the same night. In such limited contact time she prioritises the two most important tasks, as she has perceived them – immunisation and the registration of pregnancy. In addition, at periodic intervals she would “gather” cases for permanent family planning and for blindness control.

All the rest of her work is merely coping with the various orders and requirements in whatever way possible, hoping that a surprise inspection does not catch her.

With a motorcycle the mobility increases dramatically making it possible to cover four or five hamlets per day, except in the most difficult areas where natural obstacles bar the way. Not surprisingly therefore the most important, often the only task seen as being achieved by the male worker is helping the female worker by providing her with transport.

With the current nature of her work, even attending to institutional deliveries becomes an impossible task. This is to be seen alongside the fact that she cannot perform deliveries where there are no facilities, or where sub centre buildings have neither a separate room nor a bed equipped for labour.

For most workers antenatal care has become almost synonymous with pregnancy registration and all other dimensions of care are relegated to the background. Tetanus toxoid has coverage of 85 %, and IFA tablets 87% distribution, but all other dimensions of antenatal care are too ineffective to make an impact. In only less than 3.33% do we have reported BP check ups- one of the most important roles in antenatal care. There are no adequate referrals of high-risk cases for those who need it. Only about 0.3% of ANCs are currently referred as compared to almost 10% which may be expected to fall within the high risk group. This poor quality of antenatal care and the lack of confidence in care at delivery seldom inspires confidence. Institutional deliveries therefore remain low even where there is an institution available.

And thirdly, to a large extent this role of care at delivery is being perceived as that of dais. The goal of institutional delivery has receded from active monitoring. At least for a broad definition of high risk cases that would include all first pregnancies, institutional delivery needs to be reinstated as a major goal but based on a redesigned approach. We note that the ANM even if she is staying there is available only for one or two days during most of the day and thus would be unavailable if a woman comes in labour. Any site of institutional delivery needs to be a 24-hour site. Literally it is 'back to the drawing board' if we want to retain institutional delivery as goal.

□ **Male Multipurpose Worker**

The Male workers' perception of work priority as we saw earlier is primarily malaria control and then curative care as well as assistance in camps and in immunisation. If we look at what constituted their last seven days of work there is a bewildering variety. One MPW may report immunisation on all six days while another reports blood slide making on all six days. A third would cite sputum collection and health education. A fourth would state village tours to assist ANMs and so on. It was not possible to generalise the data on this to achieve any general description of their working week. Even if we see their responses as not truthful enough it is interesting to observe the diversity of what they think they ought to have been doing.

The clear message is that there is no clarity on the use of the male MPWs. Depending on perceived priorities, and skills they themselves take on roles or are assigned tasks in an adhoc manner.

Discussion

One observation is that the above pattern of work would have a very limited impact on health status. For one, immunisation can help lower measles related deaths further and has successfully eliminated polio but since the other diseases are very low or in the case of BCG, the immune effect is very minimal – no further appreciable decrease in IMR and health status are likely to accrue from immunisation. As regards care in pregnancy, we can see that apart from registration of pregnancy and immunisation against tetanus not much advance has been made in all other parameters. These two activities along with a limited amount of effective anaemia control will together make very little impact on pregnancy outcomes and maternal mortality. This is compounded by the absence of a qualitative improvement in antenatal care and better utilisation of institutional facilities and referrals for high risk cases. Even quantitatively the coverage is poor.

Other tasks like slide making are more ritualistic. Few of them are reported and percolation of reports back to patients in time never occurs. It would make for good surveillance but then most of Chhattisgarh fulfils all criteria of epidemic malaria.

There are many listed functions of the MPWs that just do not happen. For example, health education or meetings with adolescent girls, or providing first aid, or providing prompt treatment for acute respiratory infection rarely take place. There are also many functions of MPWs that are not emphasised but do take place, like identifying and mobilising cases for cataract surgery, and curative care work. One needs to look closer at some of the health camps – which are generated by various vertical programmes and carried through with little impact while diverting away time from priority areas.

The work pattern of sector supervisors seems to be focussed on camps- with little effective utilisation of these services towards the larger goals. In the absence of their use as in-service trainers, their supervision can at best be to ensure that at least the schedule described above is followed.(Discussed in Chapter 5 in greater detail).

In practice, the multipurpose workers are often able to cope because of some help from select members of the community. These belong to different types, due to different programmatic

origin and the experience can also vary between districts. Thus in some districts there is a fair degree of help from depot holders. Generally depot holders are male youths who are given a stock of drugs to dispense when needed- of which chloroquine is the most regular and most actively promoted. None of them receive any training what so ever and there is no system of refilling their stocks except what the male worker replaces now and again.

Another category of help is from community health workers left over from an earlier scheme. These are much older men and their availability is limited to a few villages, but they are making a significant contribution in many villages. There has been little or no training for over 15 years at least.

A third category is the malaria link worker. This is perceived as an active help both in making slides and in stocking and delivering chloroquine to fever cases. They receive a paltry Rs 50 per month which is said to make a significant difference. Male multipurpose workers in particular report positively about this group – as it is their work largely that this group takes over.

CASE STUDY :

The Abujhmaria health worker :

We visited Orcchha block in mid June. The block medical officer is a bright alert officer. A graduate of Gwalior medical college, he is part of the Madhya Pradesh cadre but quite unhappy as he is unable to get relieved and join duty there. He has been trying for years for transfer and it appears no nearer. His block looks after a population of 22,000 and this is divided into 28 sections. This is a rather remote and difficult tribal area inhabited by the "primitive" Abujhmaria tribals. There are three PHCs in the block, two of which are approached from here. Another PHC with 5 sections and a population of 1000 is linked to Narainpur. and not directly administered by him.

There are, he tells us 28 vacancies and only 18 posts are filled. This was predictably his perceived major problem. Recently another 16 were posted but only 9 joined. Thus we have 27 persons against 23 sections which should have a maximum of 46 health workers.

On the other hand the MPW per population works out to 777.7 which is not bad at all. The norm per sub centre has been fixed at 912. Arguably this is as far the state can go. If all the vacancies were filled we would have 46 MPWs for 21,000 population which would be about one per 456 or comparable to even what voluntary community health workers look after.

On both days of our visit we were accompanied by two MPWs Mr. V. S. P. and Mr R. R. B. posted at Kudmel and Hitapara sections respectively. After initial hesitation they became quite friendly and we could freely discuss their work and go around with VSP as he accomplished his tasks in the villages we visited.

Mr VSP is 48 years old and looks older after having served 20 years in the department all of it at Orchha. He had completed 10th class when he joined in 1983 as a vaccinator and then in 1984 he became MPW. He did three months of training in RCH then. Then in 1996 he remembers another 6 days of training at Kanker. That was the extent of his training.

Mr VSP tried for transfer thrice during this long innings and after he lost a fair amount of money in the third unsuccessful attempt gave up all hope of transfer, established his family at Kondagaon –a good 90 km away and shuttles between home and place of work ever since. He has four villages to look, after made up of nine habitations and a population of 1230. The furthest habitation is three hours walk away – a distance of about 12 kms. Most other 'paras' can be approached from a central village ,on the main road where he leaves his motorcycle, on which he commutes from Kondagaon. His headquarters HSC is in the panchayat building and there is also a female MPW posted here.

He defines his job as four – malaria work, maternal and child health, management of symptomatic illness and referral.

Mr VSP has picked up the local language fluently and acted as our interpreter with ease. He has a good understanding of abujhmaria customs and even some grudging respect for some of their healing powers. He can be quite appreciative of some of their strengths. Then he starts his work and he becomes transformed. His work is either house visits or calling a meeting at the ghotul. Once the tribals assemble at the ghotul he listens to their complaints and doles out medicines and ointments which they take eagerly. He talks to them like children repeatedly admonishing them "I will beat you up properly if you do not take this fully" (main peetoonga agar nahin liya to). He cajoles a few to get a blood smear which they avoid. Many who get pricked do not have fever but he tells me "if I do not get my quota of slides done people like you will not let me go either." I ask him what ointment he dispenses so frequently. He has no clue. It did not even appear like a relevant question to him. Then he delivers a short sermon – more like an admonishment on getting immunised – "it will protect against all diseases." Then he turns to us – his work is done. "Let us go. They will not understand more."

The abujhmaria are quite friendly to him. They see him as a medicine man. For some type of problems they prefer their local healers – like an animal bite for example, and

for others - more trivial conditions perhaps they find the MPW useful.

We visited a health camp where a number of MPWs were supposed to have gone thus accounting for their absence from their headquarters. The camp did have three MPWs present but no audience. They told me that the money had to be expended on family counselling camp on STDs by the end of this month. The audience would be coming they assured me. They could not even remotely relate how they were going to discuss sexually transmitted diseases with them. Their knowledge on this was also scanty. When all three failed to tell the dose of chloroquine - one gave up.

Discussion

Most health workers remain completely alienated from their work. Certain monitored activities are to be seen to be fulfilled -like making slides and giving some immunisation. That was the limit. There is vast cultural gap between the health care providers and the people they serve and the system has inadequately recognised this, let alone addressed it.

These problems we may call the problem of the 'last mile'. Even after the MPW is recruited, deployed and monitored, health care needs a caring attitude. The lack of training, inadequate workforce management policies and an inadequate understanding of culture - not only of the tribals but of the health care providers, combine to deny this dimension of health care in the health care systems.

The case study above is purposively chosen, though it is probably an extreme example, as it shows, more like a caricature, the nature of 'last mile' problems that plague the achievement of health for all.

Our analysis revolved around three basic questions:

- ☐ *Do we have adequate human resources at sub-centre level?*
- ☐ *How well are the existing personnel able to fulfil their job responsibilities, and deliver effective care to the population?*
- ☐ *What are the structural impediments to the functioning of the Subcentre?*

Our recommendations are therefore specific to reducing the negative effects of these factors, in order to bring about a qualitative change in the performance and a better management of the workforce in the public health care system of Chhattisgarh.

Recommendations for Strengthening Subcentre Level Services

Several policy recommendations arise from our foregoing analysis of field functionaries at sub-centre level. Many of these policy changes will have to be seen in relation to policy changes suggested at other levels in the health care system, including those related to the Mitandin programme, which complements the functions of field functionaries at the village level.

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- ☐ Do we have adequate human resources at sub-centre level?,
- ☐ How well are the existing personnel able to fulfil their job responsibilities, and deliver effective care to the population?
- ☐ What are the structural impediments to the functioning of the Subcentre?

The overall observations are :

- ◆ That there is a significant shortage of human resources, especially when taken in relation to topography and job responsibilities.
- ◆ That several factors have seriously affected their performance in the past.

Our recommendations are therefore specific to reducing the negative effects of these factors, in order to bring about a qualitative change in the performance and a better management of the workforce in the public health care system of Chhattisgarh.

Our recommendations are grouped as follows :

1. Location of sub-centres/ Infrastructure policy
2. Out-reach activities
3. Transfer policy
4. Promotion policy
5. Work elements/job responsibilities/schedule
6. Expenses of MPWs (travel and stationeries)
7. Drug supply
8. Personal security
9. Training policy – Considered in chapter 9.

1. LOCATION OF SUB CENTRES

It is necessary to rationalize location of sub-centres in the state. The following five essential steps should be followed in the location policy :

- ◆ Map all villages with existing sub-centres in all blocks.
- ◆ Demarcate various sections according to population norms fixed for areas with primitive populations, tribal populations and non-tribal populations.
- ◆ Consult local population, including gram panchayats for selection of sub-centres to arrive at practically possible locations where people from that cluster of villages find it easier to come to.
- ◆ Ensure that the Janpad panchayat approves the location.
- ◆ Get the local engineers and PWD also to approve the location, and Consult CMO for final approval of location.
- ◆ Construct the building whenever funds become available.

We could make use of a GIS based application for this purpose. We also need to take into account economic activity – like the village weekly market and locate it in tandem with such activity so as to make it easier and more likely for people to access the subcentre. We note that many MPWs reported stationing themselves at markets on market days as one effective strategy of outreach that they were currently using.

Evidently, it is not possible to complete the work of relocation of HSCs for the entire state in a year or so. We may begin this exercise in a few blocks in a few districts and build on the experience to cover other districts over a period of 3 to 5 years.

It is necessary to have a time bound plan with matching allocation of resources for completing the buildings. If such a plan were there, along with revised policies for choosing location and full utilisation of the facilities, it would be easier to raise funds from external donors for these buildings. Such a plan for each district will also help prioritize resource allocation during periods of financial pressure in the future. This aspect of rationalisation of Subcentre would therefore be integrated with the block plan (EQUIP programme) as explained in chapter 11.

We could make use of a GIS based application for the purpose of optimising subcenter location. We also need to take into account economic activity – like the village weekly market and locate subcenters in tandem with such activity so as to make it easier and more likely for people to access the subcentre.

We note that many MPWs reported stationing themselves at markets on market days as one effective strategy of outreach that they were currently using.

It is necessary to have a time bound plan with matching allocation of resources for completing the sub-center buildings. If such a plan were there, along with revised policies for choosing location and full utilisation of the facilities, it would be easier to raise funds from external donors for these buildings.

We recommend that the current RCH outreach camps (more proposed than actually taking place) should be integrated with the Mitadin programme. The RCH camps should take the form of a health department's response to the service requirements perceived and articulated by the habitation – coordinated by the Mitadin and her team.

2. OUTREACH ACTIVITIES

We recommend that the current RCH outreach camps (more proposed than actually taking place) should be integrated with the Mitadin programme. This will have mutually reinforcing effects. In between camps, the Mitadin would continue health activity in the village with the assistance of the women's health committee and supporting visits from the ANM. The RCH camps should take the form of a health department's response to the service requirements perceived and articulated by the habitation – coordinated by the Mitadin and her team. This is essential to prevent a lot of wasteful expenditure in efforts and in resources that camps often become.

The tasks at the village level are too numerous and too culture specific to be achieved adequately by a paramedical worker coming from outside without adequate support and participation from within the community. The Mitadin programme has adequately addressed this dimension but it requires be persisting with and building upon. The success of the Mitadin programme requires a number of stringent conditions outlined in SHRC working papers –2. It is relevant to emphasise here that involving block level motivated NGOs and CBOs in providing support and training to Mitadins and in organising community support is yet another resource that needs to be drawn in to the health system to make an adequate impact. These (Mitadin and local NGOs) taken together would go along way to making the HSC and the multipurpose worker more effective.

The tasks at the village level are too numerous and too culture specific to be achieved adequately by a paramedical worker coming from outside without adequate support and participation from within the community.

Earlier attempts in this direction include the community health volunteer (1975), the village health guide (1984) the Jan Swasthya rakshak (1987), the Janswasthya Rakshak (1995) and the drug depot holder, and the malaria link worker. To various degrees and various ways these health volunteer programmes fail to deliver as a token payment never suffices to provide adequate motivation and as the mechanism of training and support have seldom been worked out. However despite all the criticism of this community health worker approach and the frank scepticism about its chances of success the directorate is forced to consider another version of these schemes as without them the problems posed by this dispersion of the population cannot be surmounted. The Mitadin programme is a community health worker programme launched in 2002 which tried to learn from these past experiences and to build on it. The

details of the approach are available as a separate document. (SHRC working papers –2).

Another approach to increasing outreach has been to focus on holding periodic RCH camps. The RCH camp scheme envisages that an outreach services delivery camp will be organised in each village at least once a month. The MPW (F) was to be present in this camp and will deliver a package of essential services. The other village level functionaries- the anganwadi worker, the village kotwar and village level PRI representatives would also be involved. Earlier outreach functionaries, like depot holders and community health volunteers, who provide voluntary assistance would also be involved. Sufficient publicity of the camp was planned beforehand so that all the people of the village are able to get the benefit of the camp. One MPW (F) was expected to organise more than 4 outreach services per month, as she has to organise one session each month in her headquarters village as well. That works out to one camp per week. The experience on this RCH camps so far (before the Mitadin programme was launched) is sketchy and there is almost no data available nor adequate information on its contents. Reviewing these camps in interviews it seems that often the RCH camp amounts to a scheduled visit by the MPW usually at the anganwadi of the village.

The experience on this RCH camps so far is sketchy. ... Reviewing these camps in interviews it seems that often the RCH camp amounts to a scheduled visit by the MPW, usually at the anganwadi of the village.

We recommend that the RCH camp approach be restructured by integration with the Mitadin programme. The most important dimension would be that the Mitadin and therefore the community would be aware of what service gaps are there and therefore should be able to articulate what they expect of the camp. A package of 17 essential services may be delivered at any outreach camp- but what is finally delivered would depend on what are the service gaps reported. A high educational content is to be built into these camps.

At the end of this chapter we have given a table delineating the role responsibilities of the Mitadin and the MPW, which explains how their work needs to be redefined so as to make outreach activities effective.

A package of 17 essential services may be delivered at any outreach camp- but what is finally delivered would depend on what are the service gaps reported. A high educational content is to be built into these camps.

A clear policy on transfer is a well-perceived and long overdue reform measure.

*All postings in the district shall be classified into
Very difficult (C)
Medium difficulty (B)
Choice postings (A)
Every staff shall be required to do at least five years in difficult area. And ten years in an area of medium difficulty. After ten years in one area transfer is mandatory as also a matter of right, but can be according to choice if the chosen post is vacant.*

3. TRANSFER POLICY

A clear policy on transfer is a well-perceived and long overdue reform measure. A committee composed of some senior officials, some motivated workers identified by the department and some representatives of the workers service associations should evolve such a policy that is considered fair, transparent and easy to implement at the earliest.

The following principles should be considered while developing the transfer policy:

- ◆ Transfers shall generally be within the district of appointment and inter district transfers shall be considered only as a special exception; If MPWs could be a block level cadre appointed and supervised by janpad panchayats and BMOs, with transfer only within the block, it would be even more welcome.
- ◆ The authority for the transfer shall be a three person board chaired by the chief medical and health officer of the district, with one of the board members appointed by the district collector and another by the employees association.
- ◆ A roster of request for transfer should be maintained. Transfer shall be considered in that seniority. Within the same transfer seniority, service seniority shall prevail.
- ◆ All MPWs may apply for transfer stating their preferred choices.
- ◆ All postings in the district or block if it is block level cadre shall be classified into
Very difficult (C)
Medium difficulty (B)
Choice postings (A)
- ◆ Every staff shall be required to do at least five years in difficult area. And ten years in an area of medium difficulty.
- ◆ After ten years in one area transfer is mandatory as also a matter of right, but can be according to choice if the chosen post is vacant.
- ◆ Mutual transfers shall be allowed but without contradicting any of the above clauses.
- ◆ Persons in the last ten years of service may be exempted from mandatory transfer.
- ◆ All promotions may be considered only after five years in

difficult posting or ten years if medium posting is completed

4. PROMOTION POLICY

At present, promotional avenues for MPWs are very limited. She/he can be promoted only to the level of LHV, or Sector Supervisor. At present, these are filled in on the basis of seniority. This may continue and urgency needs to be given to its prompt implementation. For a number of years now this promotion is overdue.

We recommend that the current practice of a six month training of MPW- females before they are promoted to LHV is to be retained and improved on by using it for multiskilling. The current lack of LHV training facility (due to the earlier centre serving this area having devolved to the Madhya Pradesh state) needs to be redressed by creating a new centre.

We also recommend that the same practice be extended to male MPWs also. By providing male MPWs with six months mandatory training before promotion we can ensure multiskilling as well as greater ability to play supportive supervisory roles that they currently lack. It is also irrational and discriminatory not to require such training for men while insisting on it for women.

We also recommend an additional fast-track promotion system for which a portion of total sector supervisor posts (25%) may be reserved. This is for promoting MPWs on the basis of their willingness to serve in difficult areas if they had not done so in the past, and an examination of their skills and knowledge after a minimum period of service say, seven years of service.

We expect that this will motivate some enthusiastic functionaries to volunteer to serve in more difficult areas. If those promoted are not able to fulfil their commitment and get transferred to non-difficult areas before fulfilling their 5-years, their appointment as LHV/Sector supervisor will be revoked and they will be reinstated as MPWs. For those MPWs already in difficult areas, a raise in salary equivalent to LHV scale may be provided if they are promoted in this channel, which may induce them to continue their services in these areas.

We recommend that the current practice of a six month training of MPW- females before they are promoted to LHV (Sector supervisor) is to be retained and improved on by using it for multiskilling. ...We also recommend that the same practice be extended to male MPWs also.

We also recommend an additional fast-track promotion system for which a portion of the total sector supervisor posts (25%) may be reserved.

As posts of supervisors are limited, one time- bound promotion from a selection cadre to a senior cadre after ten years of service should be available for all.

We understand that in difficult areas sector supervisors would have to play a major role in running 24 hour services at sector level (see along with recommendation on multi-skilling in next sections). In such a context such a parallel channel where some younger more dynamic persons become available at the supervisor grade would be useful to initiate this process.

All other service promotions and benefits shall be on time-bound seniority. As posts of supervisors are limited, one time- bound promotion from selection cadre to a senior cadre after ten years of service should be available for all.

5. FINANCIAL BURDEN OF MPWs

Both our survey and several individual encounters with field functionaries have brought to light the financial burden borne by them due to routine official work.

The department of H&FW should provide for adequate allowance to carry out routine paper work. ... Also, unfair reductions and false statements on expenses made on travel and other programme purposes should be eliminated.

The department of H&FW should provide for adequate allowance to carry out routine paper work. Payments should be prompt and be made on half-yearly or annual basis.

Also, unfair reductions and false statements on expenses made on travel and other programme purposes should be eliminated. The assistance cell (discussed later) should be available for confidential complaints in this regard.

6. WORK ELEMENTS/ JOB RESPONSIBILITY

Several of the factors that affect the work performance of MPWs are related to the range and nature of key functions they are expected to carry out. These functions affect directly their ability to schedule their work in the areas they cover and therefore their ability to deliver care of reasonable quality.

It is, therefore, necessary to pay greater attention to these aspects and bring about the maximum possible changes that will enable and motivate MPWs to perform better. Our recommendations on these crucial aspects are given below :

- ◆ Allocate specific geographical jurisdictions within each sub-centre to the two MPWs. This means, each MPW will cover only 50% of the population in each sub-centre (whether tribal

Allocate specific geographical jurisdictions within each sub-centre to the two MPWs. This means, each MPW will cover only 50% of the population in each sub-centre

or non-tribal areas), and thus will considerably reduce the logistic and other difficulties that they otherwise face. Officially, there are two MPWs in each sub-centre. Therefore, such reallocation of geographical coverage (based on population norms) will not impose additional financial burden on the government.

- ◆ All male MPWs may take equal share of all dimensions of RCH care – especially in immunisation and antenatal care only. Care at delivery and IUD insertion may be seen as exclusively the female MPWs work. Given the level of care that is envisaged gender issues will not affect utilisation of even antenatal care. Similarly, in malaria control women would have the same responsibility- which in practice they already have.

- ◆ We also recommend that only female MPWs should be appointed in the future for the sub centers. Thus, every sub centre would have two female MPWs instead of one male and one female – covering 1500 population each in tribal areas and 2500 population each in non tribal areas. This is not done by removing the male MPW but by multi-skilling him and reallocating him gradually, while filling the resulting vacancies with female cadre. By having two female MPWs available per sub-centre we do not need to open more sub-centers for better coverage. Rather by optimising location and distributing headquarters days between them we can ensure that the facility is open four days a week and is easily accessible.

- ◆ It is necessary to facilitate and if needed compel MPWs to tour for three days a week, instead of the present one or two days a week. One day a week should be devoted to reviewing and drawing supplies from PHCs. The remaining two days a week should be devoted to clinical work and other services provided at the sub-centre. These two days are fixed and her clientele should know that she is available there on these two days.

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By having two female MPWs available per sub-centre we do not need to open more sub-centers for better coverage. Rather by optimising location and distributing headquarters days between them we can ensure that the sub-centre is open four days a week and is easily accessible.

Mobility may be seen as a priority and the MPWs may be facilitated to avail of bank loans to buy two wheelers.

In each field visit she should also hold a meeting with one of the following focal groups: Mitadin programmes' women's health committee; adolescent girls group; pregnant women, and a general village meeting with the "panchs" participating.

It is extremely important to develop a mechanism to sustain interactions between MPWs and Mitadin. Such a mechanism is also required for the long-term success of the Mitadin programme.

- ◆ Mobility may be seen as a priority and the MPWs may be facilitated to avail of bank loans to buy two wheelers – with a fuel allowance that allows touring. This allowance may be given only when they have learnt driving and got their license.
- ◆ In each field visit, she should cover a prefixed number of households and hamlets such that she visits all her hamlets at least once a month in difficult areas and once in two weeks where possible. By coordinating with the Mitadin she would know which families are priorities for visiting. In each field visit she should also hold a meeting with one of the following focal groups: Mitadin programmes' women's health committee; adolescent girls group; pregnant women, general village meeting with the "panchs" participating.
- ◆ Once a month he/she should attend to Block level review and training.
- ◆ He/she should be spared from irregular camp work that otherwise will hinder his/her routine work. It should be possible to conduct village and hamlet level camps during his/her tour days, but again not on a routine basis- rather to complete identified service gaps and needs.
- ◆ These camps could serve as a meeting points with Mitadin, health committee members, and others related to his/her regular functions and be driven by service requirements perceived and identified by Mitadin and her team as well as by the MPWs themselves.
- ◆ Inter-face with Mitadin workers : It is extremely important to develop a mechanism to sustain interactions between MPWs and Mitadin. Such a mechanism is also required for the long-term success of the Mitadin programme. Keeping in mind the various demands on MPWs and our the vision of Mitadins at village level, we propose the following complementary roles that they can effectively perform, as they both develop their capacity to learn and deliver over a period of time. In the table at the end of this section we provide not

only the revised list of functions that MPWs would be expected to perform but also indicate functions that will require interface with Mitans.

We are of the view that with the restructuring of the sub-centre to have two female MPWs and with the above redefinition of MPWs functions and with delineation of the ways in which Mitans could interface with them, we would have enhanced the capacity of HSCs to deliver comprehensive health care at village level.

PROPOSED REVISION OF JOB DESCRIPTION OF MPW

MPWs job description for both male and female worker would now read :

- ◆ Immunisation- Children and pregnant women- largely at the village visit and camps but supplemented by immunisation at the sub centre.
- ◆ Ante natal care and post-partum care at sub centre – with visits to those pregnant women unable/unwilling to come
- ◆ Motivation and facilitation for all methods of contraception
- ◆ Training and support to Mitans and local women's health committees
- ◆ Regular house visits, such that every household is visited once every month(or two months in difficult areas) for a set of case detection, follow up and counselling activities along with first contact curative care where required.(this includes all national programme related activities)
- ◆ Focal group discussion/health education sessions/ health camps
- ◆ Curative care during field visits on three days and at sub-centers on two days
- ◆ Response to epidemic using a graded epidemic response protocol.

We are of the view that with the restructuring of the sub-centre to have two female MPWs and with the above redefinition of MPWs functions and with delineation of the ways in which Mitans could interface with them, we would have enhanced the capacity of health sub-centres to deliver comprehensive health care at village level.

This job description of the MPW as redefined above should be an achievable and monitorable goal as compared to the current omnibus job description.

We recommend that the expanded list of drugs, adopted for MPWs, be implemented at once. ... Systems where supplies and minor equipment flow in from district level warehouses in a routine manner are essential.

The choice of village for a sub-center must conform to a block level plan drawn up. The decision to build a government building must be preceded by the Block Medical Officer and woman health supervisor and female MPW posted there certifying that the intra village choice of location is appropriate. Till such time these sub-centers can continue on rented accommodation.

In addition to the above, male workers would have the following tasks :

- ◆ Addressing male youth on adolescent problems and STDs control.
- ◆ Interaction with panchayats and with local leaders for facilitation of health programmes.

In addition to the above, female MPWs shall have the following tasks :

- ◆ Assistance at child birth (Largely at home but also institutional - only in designated HSCs)
- ◆ IUD insertion.

In conjunction with all the tools developed for the Mitaniin programme (register, referral forms, service gap identification forms, NGO participation) and the related MPW guidebooks. This job description as redefined above should be an achievable and monitorable goal as compared to the current omnibus job description.

7. DRUGS AND SUPPLIES

We recommend that the expanded list of drugs adopted for MPWs be implemented at once. This is to be accompanied by a booklet on Standard treatment guidelines and a drug formulary which would enable MPWs to expand the curative care they provide. Training on this and making this standard treatment guidelines available widely would also have to be expedited.

Supplies and equipment distribution mechanisms are far from adequate. Systems where supplies and minor equipment flow in from district level warehouses in a routine manner are essential. A number of the equipment that MPWs use require frequent replacements- like BP apparatus and thermometers - and they should also be therefore a part of supplies management.

8. ACCOMMODATION

All accommodation and sub-centers should be built only if land is made available at a more accessible and secure area. The choice of village must conform to a block level plan drawn up. The decision to build a government building must be preceded by the Block medical officer and woman health supervisor and female MPW posted there certifying that the intra village choice

of location is appropriate. Till such time these sub-centers can continue on rented accommodation.

It is desirable to link accommodation with sub-centres. The current design is adequate. It needs two more rooms if the recommendation on two ANMs per SC is accepted. Even then it would be only 800sq ft or about 3.6 lakhs per SC. To completely fill current gaps in sub-centre buildings it would take about Rs 86 crores – or about Rs 17 crores per annum over a 5 year period.

It is best to prioritise construction of new building in those sub-centres where there are no rooms available on rent nor alternative buildings available for use as sub-centre infrastructure and then move to other centers. Since institutional delivery is not being insisted in all centres at HSC level – rented accommodation with stores and paid for by the government should be adequate for most HSCs.

To guard against under-utilisation of these facilities, we recommend a block by block approach (see chapter 11–EQUIP approach.)

9. PERSONAL SECURITY

(The Supreme Court has already laid down the procedures under the VISAKA guidelines)

We recommend a Women Employee Assistance Cell (WEAC) in all districts that will provide legal aid, counselling and protection and some degree of grievance redressal particularly to the MPW female workers.

The WEAC should meet every quarter and have a confidential postal access. It should take up all issues confidentially and in non-confrontational manner. It should not hesitate to recommend firm administrative or legal action where necessary, with adequate publicity for it to act as a deterrent. The WEAC should be headed by a woman outside the health department – with some experience of work on women's issues. The WEAC should be nominated by the district collector in consultation with the chief medical officer.

10. TRAINING POLICY

See chapter- 9

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INTEGRATING MITANIN & MPW JOB DESCRIPTION

Functions of MPWs	How could Mitanin help MPWs
Carry out Immunization programme. Use data from Mitanin registers on a monthly basis to update her own registers.	Maintain registers for her village which tracks which family has not received the service due.
Provide pregnant women with complete ante-natal care either at sub-centres or at RCH camps. Attend to those that do not show up at headquarters or camps at their residence.	Encourage pregnant women to seek complete ante-natal care either at sub-centres or RCH camps.
Provide home delivery care to as many women as possible. Provide sub-centre delivery only if it is not a high-risk case and if home environment unsuitable for delivery. Not to insist on institutional delivery at sub centres- except in special circumstances which are to be laid down. Refer all institutional deliveries to PHC or CHC in case of complications.	Encourages pregnant women, especially high risk cases for institutional delivery as part of her family visits and counselling work. Encourage dais to get trained and follow five cleams
Do survey of target couples and provide service delivery for Condom and oral pills, do IUD insertion, and bring in cases for sterilisation.	Put women who want to limit family size in touch with ANMs and promote spacing and work against early age of marriage.
Motivation for contraception.	
Provide basic curative care and follow up care to doctor initiated treatment - to be assisted by an expanded list of 30 drugs and minimal laboratory tests such as urine, blood tests. Be available twice a week at the sub-centers for such consultations. Sub centre is kept open four days in a week by the two MPWs taking turns.	Provides first contact curative care – largely symptomatic- with list of ten drugs. Identifies and refers cases needing higher care early.
Treat fever patients who come to SC or who are seen during fever survey or during house visits. Visit patients diagnosed as malaria/prolonged fever to ensure complete treatment. In coordination with local leaders and health department ensure reporting of tests within 24 hours from PHCs. Help Mitanins and local leaders to organise collective action on vector control.	Provide presumptive chloroquine treatment, take and send blood smear, if necessary. Encourage/Motivate panchayat members to arrange speedy delivery of slides to PHCs and reporting within 24 hours and make local vector control measures
Respond to outbreaks of epidemics. To develop a departmental epidemic response protocol for this purpose.	Alerts health department to epidemics. Asks panchayat to follow its epidemic response protocol.
Train Mitanin on early diagnosis and prompt treatment of diarrhoea, childhood pneumonia, malaria and malnutrition.	Provide prompt treatment for diarrhoea, childhood pneumonia and malaria as part of her family visits and counselling routine
Provide regular training to Mitanin on drug kit and other aspects of her work.	Help MPWs in social marketing programmes. Use drug kit to provide first contact curative care
Get regular supplies of drugs to Mitanin and collect information from Mitanin.	Assume functions of erstwhile depot holders.
Help involve local CBOs in social marketing programmes. Attend health education meetings at village/hamlet level	Identify malnutrition and related diseases. Conduct health education meetings in the village, when

(particularly for adolescents and women)

possible with MPWs attending for health education in their villages.

Carry out health programmes in primary schools. (we recommend that two MPWs in every block, specially trained may be spared for exclusively attending to school health work .The regular MPW cannot fit this in without loss to other work. The school health programme itself needs to be thus redesigned).

Hold RCH/health camps to close identified gaps in service coverage/health service needs.

Request for RCH/Health camps to close identified gaps in service coverage /health service needs.

Chapter - V

The Primary Health Centre Outreach, Structure & Function



In this chapter, we shall analyse the adequacy of primary health centers as per the existing norms and the factors that determine their performance. Through an analysis of these factors, we would be able to identify specific policy changes that would bring about substantial improvements in their work and thus make the primary health centers and the sub-centre system that it supervises more effective.

ADEQUACY OF COVERAGE

An area served by a primary health centre is also known as a sector. It has approximately a population of 30,000 in most areas and 20,000 population in remote and tribal areas.

Unfortunately a large number of sectors do not have primary health centers- so in effect a primary health centre may cover more than one sector. Thus the data from the districts shows that there are 748 sectors but only 510 PHCs in them - a serious shortfall of 238 PHCs.

We can see from the table-16 that the population per sector is near the norms but the population per PHC is nowhere near it. We also note that even the number of sectors as currently demarcated would increase marginally if we kept to norms.

Table-16 : Adequacy of PHCs and Sectors

District	Popn. (2001)	Blocks	CHC	Av popn/ CHC	Sector PHC	Av.Popn/ PHC	Sector	Av popn/ Sector
Bastar	1302253	14	10	130225	54	24115	65	20034
Bilaspur*	1993049	10	10	199305	49	40674	66	30197
Dantewada	719096	11	9	79896	34	71909	47	15299
Dhamtari	703569	4	2	351785	14	50255	24	29315
Durg*	2801757	12	10	280175	48	58370	65	49104
Janjgir	1316140	09	6	219357	22	59825	46	28612
Jashpur	753096	8	7	107585	25	30124	33	22822
Kanker	651333	7	6	108555	24	27138	34	19156
Kawardha	584667	4	4	146167	10	58467	19	38978
Korba*	1032432	5	3	258108	29	35601	44	23464
Koriya	585455	5	4	117091	18	32525	23	25455
Mahasamund	943527	05	4	235881	15	62901	37	25500
Raigarh	1265084	9	7	180726	38	33291	35	36145
Raipur*	3009042	15	12	250753	44	68387	89	33809
Rajnandgaon*	1281811	9	9	142423	22	58264	36	35606
Sarguja	1970661	19	18	109481	64	30792	85	23184
Total of all 16	20795956	146	146	142438	510	40776	748	27952

Source : Secondary Data: District Reports with Directorate Health Services

The first and most immediate task becomes to close this gap between the number of sectors and the number of PHCs. (We however note that by defining it a sector the provision of one or two sector supervisors with their complement of MPWs is kept at normative ratios.)

We can also see that the relationship between CHCs and PHC are skewed. Every CHC should have about four PHCs under it. Yet there are many CHCs with only one PHC and many with only two PHCs. Thus the districts of Dantewada, Kanker have about three PHCs per CHC, Janjgir, Kawardha, Rajanadgaon only about 2.5, whilst there are districts like Bilaspur and Bastar that have the desirable ratio.

Internally within a district the variability in population per PHC is also considerable.

This 32 % deficit in number of PHCs as related to number of sectors, forms the single biggest form of infrastructure and human power shortage that the health system as a whole currently encounters.

Closing this gap would mean investing in more primary health centre infrastructure complete with labour rooms and minor operation theatres and accommodation for doctors and nurses. It would also mean finding 238 doctors more to serve in some of the remotest areas of the state. But to merit such a serious effort, to even bring it onto the political agenda, there is a need to make the existing PHCs more functional.

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Functions of the PHC

The Functions of a PHC are broadly

- ◆ To supervise and provide guidance to the sub-centers and their staff in implementing RCH programmes and other national programmes,
- ◆ To provide primary level curative cares services including referral services to the sub-centers along with basic laboratory services. A minimal in-patient service of two to six beds had also been envisaged, at least for institutional deliveries.

ADEQUACY OF STAFF

Staffing norms: The PHC by norms has a medical officer in charge, two sector supervisors, one male and one female (also called the Health Assistant and the Lady Health Visitor), a staff nurse, a laboratory technician, a compounder cum pharmacist and a dresser, a watchman and at least one other class IV staff (peon) and a chowkidar. There is also one male and one female multipurpose worker. This is because there is always one sub-centre built into the PHC to cater to local sub-centre service requirements.

The Paramedical

Given the large number of vacancies at this level, in practice staff positions are often filled up with some attempt to rationalise the various functions. Thus the trend is to have at least one doctor, one health supervisor, either the male or the female, and at least the nurse or the ANM, and at least a compounder or the dresser and one or two class IV staff.

We do not have secondary data on all districts but the few districts data we have, to make this pattern evident.

Thus the district of Bastar has 54 PHCs. of which 19 have no medical officer. But there is no PHC without LHV and the HA. There are 40 PHCs with both and some PHCs have more than the required number of LHVs because they cover more than one sector.

Given in table-17 is the pattern:

Table-17 : Vacancy pattern in PHCs

District	Sector PHC	Sector	No. of PHCs without either LHV or HA	PHCs/sectors with one of the two	PHCs with both LHV and HA
Bastar	54	65	0	23	40
Janjgir	22	46	5	17	0
Jashpur	25	33	5	16	0
Korba	29	44	7	25	12
Koriya	18	23	6	10	0
Mahasamund	15	37	7	32	0
Raigarh	38	35	15	26	0
Raipur	44	89	3	41	0
Rajnandgaon	22	36	1	14	7

Source : Secondary Data : District Reports

This is broadly the pattern we get in the primary data collection also.

Regarding the staffing pattern of staff nurses we find noted that in many places where there are no nurses, the ANM's assistance has been sought in this role. We note that in most PHCs with neither staff nurse nor an ANM assigned to play this role, the LHV is often assisting in this capacity- if at all the centre is functional. However, in a number of such PHCs even a LHV is not available. Where there is no female staff, it would be ethically and socially unacceptable for a male doctor to even examine a female patient in the absence of a female attendant.

PHC support staff

We look in table-18 at the secondary data on compounders, dressers, laboratory technicians and ophthalmic assistants plus a computed figure for the average class IV per PHC.

The first reading of the above table is that many PHCs have a compounder or a dresser

Table-18 : Staffing pattern in support staff at PHC

District	Sector PHC	PHCs with compounder	PHCs with dresser asst.	PHCs with lab.Tech.	PHCs with ophthalmic	Av unskilled worker/PHC
Bastar	54	NA	NA	NA	NA	2.27
Bilaspur	49	23	38	2	2	1.60
Dantewada	34	NA	NA	NA	5	3.59
Dhamtari	NA	NA	NA	NA	NA	NA
Durg	NA	NA	NA	NA	NA	NA
Janjgir	22	21	22	2	2	1.77
Jashpur	25	10	17	0	0	0.80
Kanker	24	17	21	2	1	4
Kawardha	NA	NA	NA	NA	NA	NA
Korba	29	18	21	3	1	2.40
Koriya	18	4	13	1	1	2.37
Mahasamund	15	8	14	0	1	3.93
Raigarh	38	23	38	1	1	1.87
Raipur	44	24	39	11	11	NA
Rajnandgaon	(22)	9	15	2	5	4.77
Sarguja	NA	NA	NA	NA	NA	NA

Source : Secondary Data, District Reports. (NA=Data not available)

and quite a few – like in Janjgir have both.

The norms envisage a laboratory technician in every sector PHC but these technicians are currently largely confined to the block PHC. Though there are some PHCs with a laboratory technician most persons in the system have even forgotten that the PHC had a basic laboratory and there is no memory of either staff or equipment having been present.

The ophthalmic assistant however was not intended for PHCs. The norm is one per CHC and there seems to be some spill over into PHCs.

The categories of class IV staff that constitute this statistic include peon, sweeper, ward boy, waterman and chowkidar. We can see districts which have high numbers of class IV staff and we can see that there are districts with very few. Inside districts also, between different PHCs, there could be markedly different concentrations of the class IV staff.

Table-19 : Personnel in PHCs

Sl. No.	Total PHCs from which data available = 46	% of PHCs which hed to post filled	Approx % if some categories are considered interchangeable
1	Doctors	89	89
2	LHVs	76.09	198
3	MPW-F	121.74	
4	Sector supervisors- Male &	58.70	96
5	Malaria supervisor		
6	MPW-M	36.96	
7	Compounder	47.83	87
8	Dresser	26.09	
9	Lab tech.	13.04	
10	Watchman	15.22	100
11	Peon	23.96	
12	Sweeper	47.83	
13	Waterman	13.04	

Source : Primary Data, PHC facility Survey

The above pattern is indicative. The variations in the primary data are wider. There are, for example, PHCs which have just a doctor and a dresser.

The average OPD attendance reported from secondary data is in the range of about 20 to 40 persons per day. Despite the 2 to 6 beds that are available in many PHCs in-patient care is almost completely absent.

These few admissions

that occasionally do take place are for normal delivery or for fever. Most PHCs do not even conduct institutional deliveries. Clearly, even the existing staff of which falls short of norms are highly under utilised.

But there are other problems that bring about further under utilization: for example, many compounders or pharmacists may well refuse to do dressings and claim lack of skills as the reason. Thus laboratory work, including such simple ones like urine testing for albumen and sugar or haemoglobin estimation cannot be allotted to them for it is not their job. And the sector supervisors are also not available for such work. Thus, no PHC has the complete complement of staff for quality care though there is considerable staff available. The primary data in table-19 shows the staff pattern available in a sample of PHCs studied.

Analysis of this data shows that local programme managers have hit upon a way of coping with this lack of staff. Re-examining table 19 we note that the sum of S. No. 10 to 13 all the class IV staff equals 100%. And similarly the sum of S. Nos. 4, 5 and 6 which includes, male supervisors, malaria supervisors and male MPWs equals near 95%, while support clinical staff also added up comes to 87%. The sum of female paramedical is almost 200 i.e. 2 per PHC.

We can see that, as a system of coping and informal rationalisation, every PHC has gravitated towards having two women with LHV skills (conduct delivery, insert IUDs etc), one male supervisor or equivalent, one of the three clinical support staff category available and one class 4 staff per PHC. We also note that at the entry level basic educational qualifications and pay scales are not vastly different – though the work required of an MPW female could be vastly more than that required of a compounder or laboratory technician. (The dresser is however class 4 in entry level qualification and pay scale). However job functions have not been formally changed nor training for playing multiple roles been envisaged.

Table-20 : Doctors in PHCs

District	Sector PHC	PHCs with no medical officer
Bastar	54	19
Bilaspur	49	4
Janjgir	22	3
Jashpur	25	2
Kanker	24	0
Korba	29	2
Koriya	18	0
Mahasamund	15	1
Raigarh	38	4
Raipur	44	2
Rajnandgaon	22	1
Total -12	374	38

Source : secondary data: district Report:

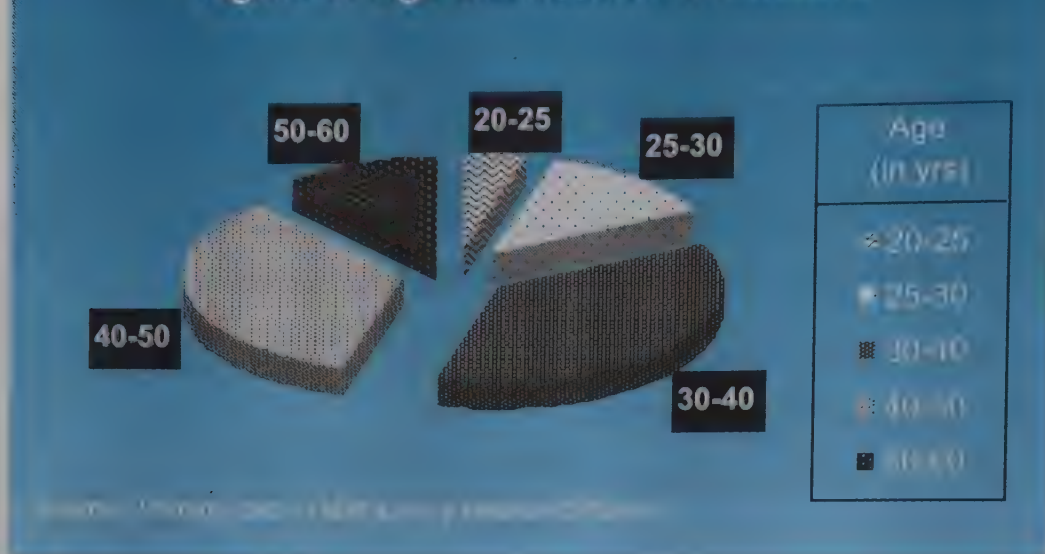
April- May 2003

(The situation has considerable improved and most vacancies of doctors are reportedly been filled by contractual appointments in these districts)

THE MEDICAL OFFICER AND THE MEDICAL ROLE

The situation of medical officers in PHCs has seen considerable improvement over the last two years. The current position in 11 districts for which data was available shows a less

Figure 8: Age distribution of doctors



than 10% gap. (Table 20)

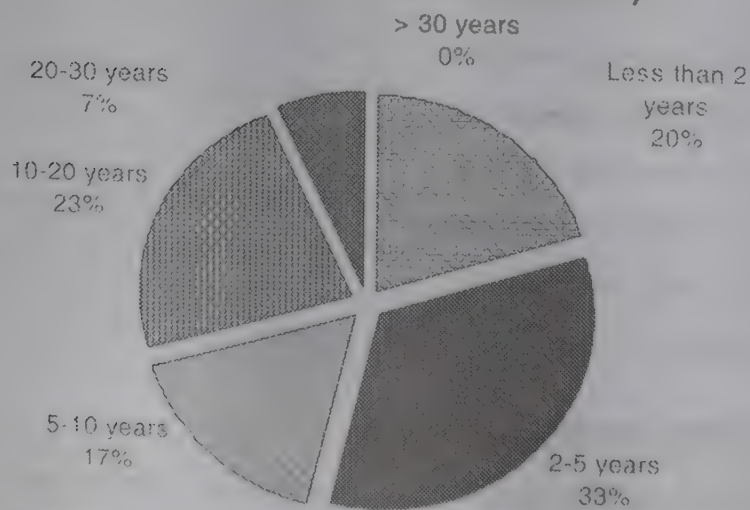
This gap is much more in some of the remote tribal districts like Bastar and Dantewada and Sarguja then in other districts. If we however consider that all sectors must have a PHC with a doctor and assuming a ten percent vacancy, the gap rises to over 38.6%.

Admittedly, finding doctors to work in remote areas remains a challenge. There are problems of housing and facilities, but even where these are not a problem, finding doctors to work in remote areas is difficult. However, in most areas today, there are doctors posted and we need to look at their characteristics and understand their constraints.

The Medical Officers Profile

We interviewed 44 doctors working in PHCs to understand their service experience. Their age structure is given in figure-8. Most doctors are young. About 46% of the doctors were above the age of 40.

Figure 9: Service period distribution of doctors (Available data- 36)



Source : Primary data, O & M survey PHC medical officers

Out of 44 doctors one was a BAMS graduate and all the others were of the allopathic stream. Of this 9.3% were women – a markedly male preponderance. Of the 43, 25 % were postgraduate degree or diploma holders and of the women 50% were post graduate.

Most doctors in the sample have a very short service period representing the vigorous attempts made by the government to fill up the vacancies. The main form of this has been through facilitating easy contractual appointments at district level. The move to ensure that postgraduate admissions are restricted to students who have put in two years of rural service, though contested in court and not cleared as such, have still made an impact on doctor recruitment. The challenge for the system is to provide a career plan and favourable environment for these young doctors so that they are not frustrated so early in life and drop out pushing the system back into a crisis of medical manpower inadequacy.

Many (45.71%) doctors had never been transferred – though we note that 28.5 %of these had only recently joined. Some doctors who had not been transferred had been in one place for over 20 years. Of those 54% who had been transferred, 14.28% had been transferred after ten years in a place. This is, however, much better than the situation with other categories. However expetations level higher & even in this group the lack of transfer policy and very limited promotional opportunities are cited by most as the main reason for their lack of motivation. In a focal group discussion on this issue – in farther districts like Dantewada, the lack of transfer policy is seen as discriminatory and the major factor leading to lack of motivation.

Table-21 : Transfer experience of doctors

Who report transfer	No. of doctor	Who does not report transfer	No. of doctor
After 20 yrs		In place 20 yrs	2.9
After 10 yrs	14.3	In place10 yrs	11.4
After 5yrs	14.3	In place 5 yrs	2.9
After 0 - 5 yrs	25.7	In place 0 – 5 yrs	28.5
Total	54%		46 %

Source : Primary Data: O&M survey PHC medical officers

The sex ratio amongst doctors is also a worrying factor. Out of 44 doctors met only four were women. Out of nine postgraduates only two were women. There is a special case for recruiting more women doctors.

All the factors that affect male doctor recruitment affect women much more. Thus the study team repeatedly met women who have been separated from husbands in the same workforce but were unable to secure transfers. Thus one lady doctor in a CHC in Janjgir works in a block, which is grossly understaffed by doctors. She has an infant at home to take care of. Her husband is at Sarguja in a centre where there are adequate doctors. Yet she has been unable to secure her husband’s transfer to the district of her posting. Nor, has she been able to get her transfer to her husband’s place of posting. Another gynaecologist we met in Kawardha,

Table-22 : Educational Qualification of 44 doctors in PHCs

Educational qualification	No. of doctors	
	male	female
Graduate MBBS	30 + BAMS (1)	2
Post graduate	9	2
	MS-3/ MD-1/ DCP-1/	MD-2
	DCH-1/MD-OG 2/BAMS-1	

had a similar story to tell. While these are problems for men, for women they must really have very high motivational levels to continue in government service despite the apparent, perceived heartlessness of the system.

We also note that eleven out of 44

doctors posted at PHCs have postgraduate qualification as shown in table-22. This has implications for motivational levels. Being posted in PHCs with such minimal facilities would be substantially under utilising their skills. Thus we have three surgeons, two gynaecologists, one paediatrician and one physician and one pathologist at PHCs whilst CHCs are almost always running short of these very specialists. We also note the presence of on BAMS in the lot – representing a policy by which vacant posts can be filled up with BAMS.

Staying at place of work

It is difficult to estimate how many doctors stay at headquarters as compared to doctors who do not. Of these how many are intermittent in work attendance as compared to those who

Almost two thirds (60%) reported travelling distances that varied from a few km to up to 85 km daily to attend to their work. It would be a safe assumption that currently as high as about two thirds may not be staying in the village where the PHC is located.

are regular is also difficult to estimate. It is somewhat easier to spot a centre where the doctor is not posted or where he never goes.

One surrogate index of staying at headquarters was to ask how much doctors had to travel to reach place of work. Thus only about one fourth of doctors (27.91%) stayed at the place of work and could walk to work and another 18.6% stayed nearby requiring a short travel. Almost two thirds (60%) reported travelling distances that varied from a few km to up to 85 km daily to attend to their work. It would be a safe assumption that currently as high as about two thirds may not be staying in the village where the PHC is located.

Skill Acquisition And Retention In Doctors And The Training Policy

It is a general perception that doctors especially those practising in remote areas are under-skilled and have no means of sustaining their knowledge levels. This is evident by the knowledge levels seen in a number of focal discussions with doctors as well as reports by the

doctors themselves and supervising officers. For example, IUCD insertion is a basic skill that they have to supervise and train MPWs in. But most doctors would never have opportunity to learn it in their medical course. Other skills like basic laboratory skills are taught but in the absence of reinforcement could be completely lost.

We find that in the last two years there has been an active programme of training for doctors. The training however has been concentrated around two topics tuberculosis and leprosy. Though undoubtedly these are vital areas and the training is welcome, the doctor has a number of other functions too and there seems to be inadequate training on all these aspects. Even in RCH areas only 13 were trained. We must also note that many doctors have received one or more trainings and some have received none. The current practice is that to request the CHMO to depute some medical officers whenever a training programme is introduced. And whosoever is willing and can be persuaded may be sent. Often there is no clear plan of using them as resource persons after they return. Again, unless a training roster is maintained and a clear policy enunciated that in a given period a fixed amount of training would be achieved – much progress is not possible.

Training programme themes depend almost exclusively on programme funds made available from centrally sponsored national programmes – almost exclusively and most are one or two day sensitisation programmes(except in RNTCP where they are of longer duration).

Unless training programmes are improved upon and made to subserve the goals of adequate knowledge and skills in the medical team, as defined in the graded health service norms (See annexure-2) the needs of the health system as a whole may not be served.

Table-23 : Distribution of trainings achieved by year and Topic of training

Trainings	No. of doctor trainings since 2000	No. of doctor trainings since 1994 - 2000
TB	15	-
RCH	4	4
Leprosy	19	1
IPP6	1	2
HAP	-	1
CSSM	-	6
Aids	3	1
Pulse polio	2	-
Family planning surgery	-	-
Public health	-	1
Malaria		3
IEC	1	
BMO	1	
Blindness control	1	
Tribal welfare	-	1
Disability	1	
Immunization	6	
New born care	3	

We thus see a paradox. On the one hand one main focus is to get doctors to serve in PHCs and on the other hand those who are there are seriously underutilised- hardly having more than a couple of hours of work daily. ... We are clearly against withdrawing the doctor from the PHC. A synthesis would be to work out strategies to improve the doctor's utilisation even as we strengthen the paramedical contribution in this level.

The Doctors' Work Schedule

The work plan of the doctor and how he/she manages his/her various responsibilities needs to be studied further.

Data from our study shows an unvarying pattern- firstly, outpatient care and then administrative work and then attending health camps. Outpatient care is often of short duration as outpatient attendance is low. As the examination of patient is also limited and laboratory services unavailable, the duration per patient is usually inadequate. Administrative work usually consists of forwarding sector supervisor prepared reports. Even at camps there is only some cursory curative care to be dispensed.

We thus see a paradox. On the one hand one main focus is to get doctors to serve in PHCs and on the other hand

those who are there are seriously under utilised- hardly having more than a couple of hours of work daily. This observation has led some leading experts on primary health care to advocate withdrawing the qualified medical doctor from this level, leaving behind a health post staffed by paramedics whilst strengthening the CHC further. Another way of looking at this is to look at the epidemiological profile and delineate what are the incomplete tasks and the loss of access and quality that would result if we withdraw the doctor from this level. We are clearly against withdrawing the doctor from the PHC. A synthesis would be to work out strategies to improve the doctor's utilisation even as we strengthen the paramedical contribution in this level.

Adequacy of PHC infrastructure

Data on infrastructure was available from 59 PHCs.

All PHCs were in government buildings. Interestingly this varies sharply from secondary data according to which out of 513 PHCs as many as 178(34%) have no government building. Many PHCs are housed in sub-centre buildings which have been recently upgraded to PHCs. This has meant displacing the ANM from her accommodation and lack of accommodation for all the staff. The space is adequate to conduct deliveries and to admit two patients where the space is well organised. However the space would become inadequate, if the PHC is fully functional.

PHCs, which are in government buildings built for that purpose, have good infrastructure with about 6 beds, which can be even pushed upto ten beds. PHCs in panchayat and rented buildings usually have inadequate space.

61.37% of PHCs reported regular power supply and another 36.36% reported only occasional power failure. Power situation is satisfactory in this power surplus state. One PHC had frequent power failures and has a generator as back up.

The Water situation was less than satisfactory. Though most had a water source only one fourth had running tap water connected to an over head tank. A well or bore well was the commonest situation and was present in roughly half the PHCs. About one fourths report that their source is absent or inadequate.

Telephones were present in one thirds of the PHCs studied.

Only 10% of PHCs were aware of and reported having tried colour coding for wastes. Forty percent of PHCs reported having some system of disposal – 12% had incinerators, 12% went in for deep burying and 16% had a landfill.

Only 5% of PHCs in government building studied did not have doctors' quarters and all those that had quarters reported it as being in use. Only 45 % however had nurses' quarters and only 33% had quarters for paramedics, 40% for clerical staff or class 4 staff.

About 33% had staff toilets and of these one thirds (11%) were considered lacking adequate maintenance. Most other PHCs had one toilet without separate provision for staff. The condition of one thirds of these was rated as poor and the rest as fair. None were considered as being adequately maintained. One thirds of PHCs had in addition some bathing facilities.

If we define a PHC as having the capacity to conduct institutional delivery on a 24 hour basis for high risk cases, all the above patients toilets, staff toilets, bathing facilities for patients, waste disposal facilities, communication facilities for referral etc are all essential features. Clearly this has not been achieved.

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Table-24 : Drugs and Consumables in PHCs.

S. no.	Name of Drug	% of PHCs who reported being out of stock	How long a break in supply
1	Paracetamol	9.5	1 months
2	Chloroquine	9.5	< 1mth
3	Primaquine	21	1 month
4	Cotrimoxazole	33	70 days av.
5	Second antibiotic (any)	23	1-9 months
6	Iron folic acid	50	1-9 months
7	Paediatric iron	50	1-9 months
8	Vitamin A syrup	48	1-3 months
9	Albendazole	48	1 months
10	Metronidazole	19	1-12 months
11	Eye drops	57	2-3 months
12	Metochlorpramide	26	1-18 months
13	Prednisolone	88	1-24 months
14	Bisacodyl	97	1-24 months
15	Salbutamol	74	1-36 months
16	Antacid	40	1-16 months
17	Chlorpheniramine	50	1-12 months
18	Dicyclomine	50	1-6 months
19	Gentian violet	71	1-36 months
20	ORS	19	1 month
21	Anti-fungal cream	62	1-9 months
22	Anti-leprosy	40	1-3 months
23	Antitubercular drugs	54	1-12 months
24	Skin care ointment	62	1-12 months
25	Chlorhexidine	83	1-9 months
26	Condoms	45	2-9 months
27	IUD	83	1-12 months
28	OCP	45	2 months
29	Spirit	86	1-36 month
30	Slides	19	<1 month
31	HCl acid	98	1-9 month
32	Benedict's	95	1-9 months
33	Gloves	35	9 months
34	Bandages	26	21 days
35	Gauze piece	40	1-9 months
36	Sutures	69	1-12 months
37	Knife blade	52	1-9 months
38	Laryngeal/tracheal cath.	88	1-9 months
39	Syringe needle	19	5 months

Source : Primary data Facility Survey: PHCs

Adequacy of Drugs and supplies

The drugs position is perceived as good in response to direct questions. The data available from the stock positions is different, as shown in table-24.

Thus the most available drug is paracetamol of which most PHCs have abundant stock, but even here about 10% reported nil and three more had breaks in supply during the year lasting about a month. The current break was less than a month in four of the centers and less than two months in the rest.

Chloroquine is also a well stocked drug, but here too 10% had, at the time of survey of nil stock. Though the period for which it was nil was for a few days. Primaquine had a more worrying 21 % reporting nil stock.

In antibiotics a surprising 33% had no cotrimoxazole though only 7% had no antibiotic whatsoever.

Those drugs which are part of the main RCH programme of the Subcentres are - Albendazole, vitamin A, iron and folic acid tablets - adult and

paediatric. Surprisingly 50% did not have the drugs. As in many PHCs these drugs are seen as part of the ANMs kit, they may not come into the main drug stock register. Still this is an area of concern that needs to be reviewed. The availability of most other drugs was in the 33% to 50% range.

Availability of laboratory chemicals for basic tests fared the worst. Obviously they are not part of the supply system at all. The report on low availability of anti-tubercular drugs and anti-leprosy drugs is also worrying as the general perception is that the availability of these drugs is good.

We also note that many drugs that have been consciously left out of the essential drug list like nimesulide and costly multivitamins are procured and freely available even when essential drugs on the list have such gaps in their supply.

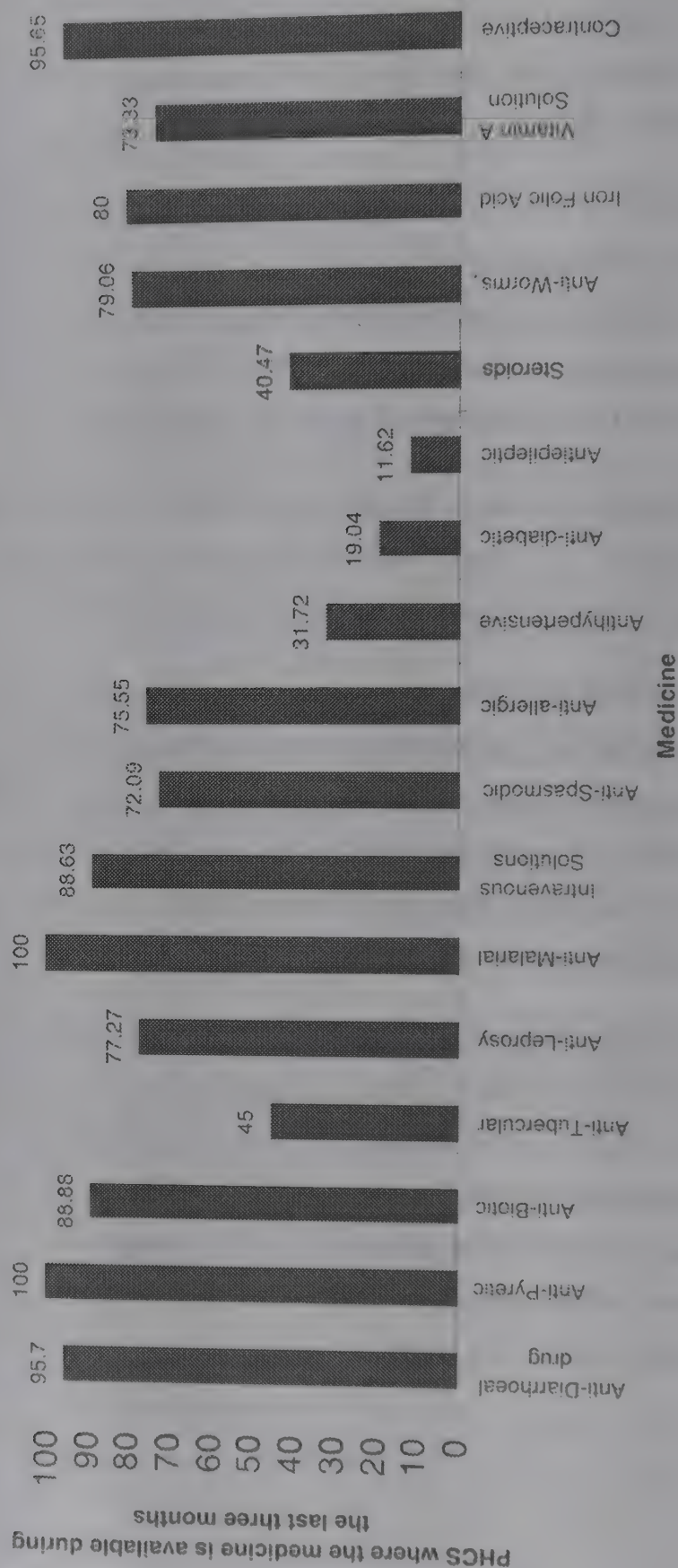
The system of supply indicates two bursts of distribution- one in the August - September periods and another in February-March period. This leaves high stocks of some drugs in hand. Often drugs are being replenished when there is already a high number available in stock- while others run out and wait months for restocking. Thus in the last three months in a number of essential drugs in a much larger sample in response to asking the medical officers we get the figures of availability in figure-10.

Theoretically, whenever a drug runs out the PHC doctor has just to indent for it and then a supply is sent. In practice most supply is driven from above and independent of needs articulated from below. This would necessarily entail higher wastage of drugs, less efficiency of their usage and lack of drugs of some categories from time to time while others are in surplus.

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Figure 10: Doctors' perception of drug availability in PHCs



LABORATORY SERVICES

There are almost no laboratory services at the sector PHC. There is only collection of blood smears for malarial parasite examination. There is not even any awareness that by the norms sector PHCs should have the capability of basic laboratory testing including a compound microscope. Most PHCs do not have a microscope and many who have are not currently using them. Only 30.5% of PHCs studied had any microscope at the PHC level.

The basic laboratory services provided at the PHC must include blood haemoglobin estimation, total count, differential counts, bleeding time and clotting time, blood smear examination for parasites, urine examination for albumin, sugar ketones, bile salts and pigments, and microscopy of urine, sputum acid fast microscopy, grams staining of sputum, CSF etc. and stool examination for ova and cysts and hanging drop examination of stools. This set would be the basic norm in any basic laboratory set. Because of the disease profile, sickling test could also be part of the menu. Surprisingly, there is a near complete absence of even blood haemoglobin estimation- a test, which is a must at the sub-centre level. Laboratory services are the cornerstone of scientific medicine. In their absence it is difficult to differentiate the quack from qualified practitioner. The use of lab services represents a mindset and a culture. To illustrate: it may be possible to diagnose and treat anaemia without blood haemoglobin estimation. But the culture of science requires that we have evidence to support the diagnosis that the level of anaemia is documented, and then improvement with treatment is documented. If this is not done the dose of drugs is not tailored to suit requirements, emergencies are not responded to, failure of compliance is not identified, contributory causes by persistent loss of blood are not identified and to Add to it the above in this state about 10% of these cases would turn out to be sickle cell anaemia or have other causes that are totally missed. The difference between the quack, the health worker and the doctor is lost if laboratory work is not insisted on.

Of the laboratory services envisaged, only blood smear examination for malarial parasite and sputum examination for AFB is being focussed on. With the same equipment and same qualification of the employee needed for these two tests, much more tests can be done and the tendency to confine testing to just blood smear examination is unfortunate. But at the sector PHC level even this is not done. The absence of laboratory technicians is cited as a

Laboratory services are the cornerstone of scientific medicine. In their absence it is difficult to differentiate the quack from qualified practitioner. The use of lab services represents a mindset and a culture.

However, the recent thrust to train male supervisors to undertake blood smear examination was a step forward in the right direction. But there were many problems in operationalizing it

reason. The recent thrust to train male supervisors to undertake blood smear examination was a step forward in the right direction. But there were many problems in operationalizing it – poor quality of training, poor motivation levels, selection of a number of older people nearing retirement, no back up to the training at the PHC level and soon.

REFERRAL SYSTEM

There is no active referral system in place. The current practice is that if a patient has to be referred he is orally asked to go to the higher centre. Occasionally, a written slip is given. There is no advantage to the patient who was referred as compared to one who chose to go directly to the higher center – a reason for many to choose the higher center on all occasions leading to excess pressure on these centers.

There is a fund placed at the disposal of panchayats for referral. The guideline is to use the fund for referral of high-risk cases of pregnancy during an emergency. Many panchayats are not aware of this provision and those who are aware do not know how to operationalize it. Even then since requirements are sporadic there is considerable under-utilisation of this provision.

IN-PATIENT SERVICES IN PHCs

Many PHCs do have four to six beds. Many other PHCs do not have beds at all. Almost no PHC admits cases on any regular basis and bed occupancy is very low. There are many reasons for this – but at some level even the intention to provide inpatient services at this level

is not there. The reasons for the low utilisation of inpatient services are discussed later in this section.

Table-25 : Age distribution of SSF

Age	No. of sec. Sup.
20 - 25	
25 - 30	
30 - 40	18.36
40 - 50	59.18
50 - 60	22.45
Total	99.99

Source : Primary Data O& M survey SSF

SUPERVISION FUNCTIONS OF THE SECTOR PHC

One of the most important functions at the sector level is to provide supervision/oversight for the multipurpose workers –both male and female. This is done by two cadres: the Sector Supervisor Male (SSM) (also known as health assistant), and the Sector Supervisor Female (SSF) (also known as LHV-Lady Health Visitor).

Sector supervisors- female

We collected data from 49 female health supervisors. From table-25 we can see that 81% of female supervisors are above the age of 40 and all have above 10 years of service and 53% have above 20 years of service.

Most of them (81%) stay within a walkable distance – implying better availability and only less than 20% commute to work from a nearby town as shown in table-26. We also note that about 1/4 are using two-wheelers to come to work. This may go up if more of them are helped to buy a vehicle.

Educational Qualification

Eighty six percent of them have completed basic schooling (6% did not even complete school) and the rest are graduates as shown in table-27.

Service period

As can be expected all of them have more than ten years service. Most of them- over 54% have had over 20 years of service. This merely reflects the fact that they have become eligible for this post only after ten years of service. However at this stage learning new skills and undertaking difficult postings would be a problem, and needs considerable encouragement and support.

Table-26 : Transport used to reach place of work for SSF

Means of transport	No. of sec. Sup.	Average distance covered
Foot/ walk	57.14	0 kms to 1 kms
Bicycle	4.08	0.5 kms to 1 kms
Moped	2.04	0 kms to 1 kms
Motorcycle/ scooter	18.36	0 kms to 5 kms (too long dis 40kms)
Bus	16.32	14 kms to 80 kms
Any other(train)	2.04	15 kms

Source : Primary Data O& M survey SSF

Table-27 : Educational Qualification of SSF

Educational qualification	% of sec. Sup.
8-9 th	6.12
10 –11 th	79.59
12 th	-
Graduate	4.08
Post graduate	10.20

Source : Primary Data O& M survey SSF

Table-28 : Service period distribution of SSF

Sum of services periods (total service period)	% of sec. Sup.
Less than 2 yrs	-
2 – 5 yrs	-
5 – 10 yrs	-
10 – 20 yrs	46.15
20 – 30 yrs	51.28
> 30 yrs	2.56

Source : Primary Data O& M survey SSF

Table-29 : Transfer experience of SSF: Seems to promotion transfer

Who report transfer	No. of sec. Sup.	Who does not report transfer	% of sec. Sup.
After 30 yrs		In place 30 yrs	-
After 20 yrs	2.56	In place 20 yrs	-
After 10 yrs	64.10	In place 10 yrs	-
After 5yrs	28.20	In place 5 yrs	-
After 0 - 5 yrs	5.12	In place 0 - 5 yrs	

Source : Primary Data O& M survey SSF

Table-30 : Distribution of trainings achieved by year and topic of training

Trainings	No. of sec. Sup. trained since 2000	No. of sec. Sup. trained 1994-2000	No. of sec. Sup. trained 1984-1994
RCH	2	22	1
IPP 6	-	29	1
Family planning	-	-	5
MPW/LHV training	-	-	18
Lab Tech	3	-	-
C S S M	11	-	-
Malaria	3	-	-
Leprosy	5	-	-
TB	3	-	-
Yaws	2	-	-
AIDS	1	-	-
Mitanin	2	-	-

Source : primary Data O& M survey SSF.

Transfer

All of them have been transferred more than once- which is much more than other categories as shown in table-29.

Training

They had all received RCH related training in between 1994 to 2000 but diverse short-term disease - specific trainings only in the last three years. Indeed 35% received no training at all in last three years. The training of LHVs is amongst the lowest for any group. Of course when they become LHVs there is a 6 month retraining course but it is not clear how many attended this and when. Normally on the basis of seniority they get selected for LHV training and after they come back from training they get appointed when vacancies arise. But with no LHV training centre in the state this has more or less stopped (See Table-30)

Despite this, LHVs are seen as the most skilled and motivated amongst paramedicals and whether it is conducting delivery or inserting IUCDs they have the skills and can even provide training.

Security was a problem for 16.32% and out of pocket expenses for tours to supervise was a major problem with over 35% reporting over Rs 500 per month expense and on registers was a smaller problem with 20% reporting an expenditure over Rs 100 as shown table-31, 32.

Table-31 : Personal burden on SSF

S. No.	Do you get	Yes
1	Money for buying stationery	8.16
2	Your Travelling allowance	49
3	Are you threatened or do you have to face violence	16.33

Source : Primary Data O& M survey SSF.

Table-32 : Extent of out of pocket expenditure

S. No.		Less than Rs 250/-	Rs. 250/- to 500/-	Rs. 500/- to 1000/-	Above 1000/-
1	How much money spent on tour	26.67	42.22	24.44	6.67
		Less than 50	50-100	100-250	>250
2	How much money spent on stationery	44.44	35.56	4.44	15.56

Source : Primary Data O& M survey SSF.

Table-33 : Age distribution of SSM

Age	% of Sec. Sup. male
20 - 25 yrs	-
25 - 30 yrs	-
30 - 40 yrs	6
40 - 50 yrs	9
50 - 60 yrs	85

Source : Primary Data: O&M study, Sector Supervisor Males.

About half have served over 20 years and another half has served between 10 and 20 years as shown in table-34.

Sector Supervisor Male

The experience with male supervisors was as follows:

Age

The vast majority of Male sector supervisors interviewed were above the age of 50 (85%) as shown in table-34.

Table-34 : Service period distribution of SSM

Sum of services periods (Total service period)	% of sec. Sup.
Less than 10 yrs	nil
10 - 20 yrs	50
20 - 30 yrs	23
> 30 yrs	27

Source : Primary Data: O&M study, Sector Supervisor Males

Table-35 : Educational Qualification of SSM

Educational qualification	% of SSM Sup.
8-9 th	9
10 -11 th	76
12 th	9
Graduate	3
Post graduate	3

Source: Primary Data: O&M study,
Sector Supervisor Males.

Education

As for Sector Supervisor Female the majority of male sector supervisors had passed high school (93%) and of this one third had completed 9th or 8th level only, as shown in table-35.

Service

Their service record is varied. Only about nine percent started as MPWs and rose to become sector supervisors. Most (54%) started as surveillance

workers who later became MPWs or Junior malaria inspectors or surveillance inspectors and then went on to becoming sector supervisors. Another 22.7% started of as vaccinators and then became vaccine supervisors and then sector supervisors. There was in the sample one NMA who had been absorbed recently. And a small 13% reported this cadre as their entry cadre and having remained static ever since - a range of 23 to 39 years.

Transfers

Most Male supervisors have been transferred often, probably a consequence of changing job profiles and promotions- but there are about one fourth who have stayed at one place all their careers – sometimes as long as 38 years.

Training

Their training is varied. Most (61%) had a one month to three month MPW training

Table-36 : Distribution of trainings achieved by year and topic of training

Trainings	No. of SSM trained since 2000	No. of SSM trained since 1994-2000	No. of SSM sup-trained before 1994
Lab tech	14	-	
RCH	2	20	
Malaria (2 days)	2		
Leprosy			4
TB 2days	4	14	
FW	1	11	
MPW			20

Source: Primary Data: O&M study, Sector Supervisor Males

period when they were converted into MPW or sector supervisor before 1984. People who have subsequently changed into it like NMA etc do not get such training. In the nineties most (76%) have had a seven day orientation on RCH, another 6 days on IPP-6 (family planning). And then in the last three

years 42% of the supervisors interviewed have had a 15 day training programme in laboratory technician course to equip them for blood smear examination as shown table-36.

We can see from the above that these categories, of staff are less trained then the persons they have to supervise. Thus, supervision on the most critical aspect of quality and content of work becomes quite impossible under such circumstances. Ideally, the supervisors must be trained adequately and they must in turn train and support the health workers they are in charge of- thus exercising a leadership for the public health programmes in the sector level. In the absence of this element, their work becomes one of collecting data and preparing reports with the only goal of satisfying progress requirements by appropriate advances made in records.

Not surprisingly in focal discussion with MPWs, especially with. female MPWs the lack of support from the supervisory staff – especially the male was a major issue. In the case of male supervisors there is even a perception that they have no work whatsoever- which may be unfair to many of them- but reflects the way that this cadre gets ignored in training, and work allocation

Out of pocket expenditure

We also note that the supervisors have a substantial out of pocket burden on travel – especially if they are conscientious about their touring. Only 54.8% report getting regular travelling allowance and even they had substantial out of pocket expenditure as shown in table-37.

Table-37 : Out of pocket expenditure on tours

S. No.	How much money spent on	Less than Rs 250/-	Rs 250/- to 500/- to	500/-Rs 1000/-	Above 1000/-
1	On tour	32%	26%	39%	3%

Source : Primary Data: O&M study, Sector Supervisor Males.

The poor attendance of the sector PHC does not reflect a low need for such services. It is more a reflection of the low quality of care currently available and the poor design of its workforce and functions.

If we dismantle this (PHC) structure just because its current performance is poor, then, in a tribal and poor state with such geographical challenges like Chhattisgarh, a major part of the population would be completely excluded from any modern medical care – which would be violative of our constitutional commitment.

The core of our recommendation is that all the staff in PHCs should be multi-skilled-which helps increase cost-effectiveness of the services provided - at the modest levels of ongoing outpatient care.

Recommendations on PHCs

Strengthening or Dismantling the PHC

During the course of the study we came across many stakeholders who suggested that the sector PHC is either unnecessary or that it is impractical. The study team disagrees. The poor attendance of the sector PHC does not reflect a low need for such services. It is more a reflection of the low quality of care currently available and the poor design of its workforce and functions. As a curative care centre it offers little more than what the unqualified clinics offer. The public health functions it subserves are all organised directly out of the CHC making the sector PHC redundant. Thus, a sputum test for AFB or a blood smear examination – if it has to go to the CHC for reporting would mean that the role of the sector PHC is undermined. This results in poorer quality of public health programmes. The medical officer posted here is often a fresh graduate and has neither the skills nor knowledge to lead the public health team. If we dismantle this structure just because its current performance is poor, then in a tribal and poor state with such geographical challenges like Chhattisgarh a major part of the population would be completely excluded from any modern medical care – which would be violative of our constitutional commitment. It is in this spirit that the study group makes the following recommendations for revitalising and strengthening the PHCs.

1. Staffing patterns and Multi-skilling

□ - The core of our recommendation is that all the staff in PHCs should be multi skilled-i.e., trained in several skills, which help increase cost-effectiveness of the services provided at the modest levels of outpatient care ongoing. For example, an ANM or LHV or a

compounder could be trained in dressing and could handle the three or four cases that require dressing a day. A separate category of dresser is not justified.

This suggestion definitely makes much sense because of the fact that many of the functionaries at PHCs such as compounders, LHV, or Pharmacists, are not engaged in their respective job description the whole day. Such multi-skilling would also have implications for rationalisation of staff at this level.

Central to multi-skilling is the principle that all staff must be required to put in an eight hour working day. This is crucial because almost all staff cadre at the PHC do not have work that occupies even two hours per day whilst only the MPW female is intensely over loaded.

□ We also recommend that multi-skilling of staff should include laboratory skills. This does not eliminate the need for laboratory technicians. In fact the qualified laboratory technicians could play a more specialised role at higher level, namely at CHCs.

Thus the recommendations would mean that in a sector we would have the staff as shown in the accompanying table-38

The transition is not going to be easy, as re-skilling a Dresser or Compounder or even health supervisors is likely to pose more difficulties than we could imagine now. We note that entry level basic qualifications for almost all these cadres have been school final examinations and technical skills required have been specific only for MPW-females. In service training and job supervision by the medical officers who themselves are retrained for this purpose would be the key to achieving this Multiskilling at the earliest. Many paramedical courses today are

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In service training and job supervision by the medical officers who themselves are retrained for this purpose would be the key to achieving this Multiskilling at the earliest.

Table 38 : Staffing pathern of the sector PHC : current & Proposed

Current sector staff		Recommendation for sector staff :		
Medical Officer	1	Medical officer	1	
Staff Nurse	1	Multiskilled women (MPW females) workers or GNM	3	Perform functions of staff nurs and LHV and ANM and ensure 24 hr institutional delivery
Sector Supervisor Female	1	Three multiskilled male workers	3	Perform function of compounder, dresser and lab. tech as well as support to sub-centre level national programmes, keep 24 hr care at PHC
Sector Supervisor Male One Health supervisor male	1	Senior multiskilled worker supervisors(male or female)	2	Provide training and supervisions to all the workers in their sector, also help in laboratory and institutional delivery.
MPW(F) or ANM	1			
MPW (M)	1			
Compounder,	1			
Dresser	1			
Lab tech(in some sectors)	1			
Six MPW(M)or one per SC with one SC inside PHC	5			
Six MPW(F) or one per SC with one SC inside PHC	5	MPW (F) or two per sub centre	10	Perform all the functions of MPWs at sub centre but at half current population norms
One Sweeper	1			
One Ward boy/waterman/peon	1	Two class IV general.	2	
One Chowkidar	1			
Total	22		22	

The study team recommends that all paramedical courses on offer need to be redesigned to regenerating multiskilled paramedical workers suitable for restructured PHC.

designed to turn out poorly qualified even hazardous curative care practitioners of allopathic medicine. Some courses concentrate on a single paramedical area. The study team recommends that all paramedical courses on offer need to be redesigned to regenerating multiskilled paramedical workers suitable for the restructured PHC. This would be beneficial not only to the public health system but also to the private health system in the medium

term and the long term. Almost all private nursing homes and clinics are assisted by such “multi-tasked paramedicals” with no qualification whatsoever – many of whom set up later as “village doctors”.

It should be noted that in the above suggestion there is no reduction in cadre involved and in real terms since many posts are vacant there would be an increase required. The increase is primarily in MPW (F). In most other categories we are looking at only in-service retraining. In future all recruitments would become through only two channels the male and the female multipurpose worker training which itself must be redesigned as male and female multiskilled paramedical workers to provide these set of skills.

The service and pay scale rules for merging all these categories without getting into legal or union tangles would be a difficult task but considering the overlapping nature of many scales and the over 120 categories of staff as of today, there is a need to do this anyway. Part of these difficulties in transition could be overcome with the offer of increments or promotions.

2. Doctors in PHCs

- We recommend that all PHCs have a 24 hour facility where at least institutional delivery, basic curative care and first aid level emergency care is available. This may be done by working the PHC in shifts with multiskilled paramedicals who between themselves are available on call for 24 hours. The doctor would be available for eight hours on working days and on call in the nights if stationed at headquarters. Through such a scheme, it is also possible to provide primary curative care services round the clock in all PHCs-

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In addition, in all PHCs considered most difficult (category C) in terms of access and working conditions, medical doctors may be allowed to visit the PHC daily or even thrice weekly along with insisting that the doctor has to stay at the CHC town or at a nearer 10 bedded PHC and provide his services over there during the rest of the time including call duties at night.

We urge that the current non-residence of doctors at headquarters (PHC) should be treated with some understanding and pragmatism.

even those that have a doctor. This would make it possible for the system to reach its goals on institutional deliveries and it would enhance the credibility of the primary health centre. This scheme may prove useful in PHCs with single medical doctors when they are on leave or on tour.

- In addition, in all PHCs considered most difficult (category C) in terms of access and working conditions medical doctors may be allowed to visit the PHC daily or even thrice weekly along with insisting that the doctor has to stay at the CHC town or at a nearer 10 bedded PHC and provide his services over there-including call duties in nights by turn. Family accommodation at the CHC should be ensured. In other words we should not insist on medical doctors staying in PHCs designated category C - most difficult. (We consider that the above approach with mobile doctors but fixed facilities may be more cost effective than mobile hospitals when combined with the use of multiskilled paramedicals.) We urge that the current non- residence of doctors at headquarters should be treated with some understanding and pragmatism. By illegitimizing their non- stay they are made vulnerable and their morale is difficult to maintain. Anyway much emergency care beyond a paramedicals' capacity cannot happen- given the level of care planned for the PHC.
- We recommend that in all PHCs with no medical doctors, only till such time as a doctor is recruited, a paramedical multi-skilled worker should be positioned to provide primary level curative care. This should be backed by weekly visits (two to three per week) of a medical doctor from respective CHCs. The paramedical worker should also be trained in emergency care

management at primary level. (We emphasise that by paramedical worker we mean the current MPWs or pharmacist or staff nurse currently in service with further training inputs and not the legitimisation of unqualified allopathic practice that goes by the name of paramedical course.)

- We recommend a Continuing Medical Education scheme for medical doctors to upgrade their knowledge and skills. This should replace the current practice of upgrading their knowledge through sporadic camps of national disease programmes. The envisaged CME¹ scheme should also be useful for promotions. A CME should be pursued as a very useful intervention strategy in health care delivery system.

¹ We can not possibly workout here the details of this CME and the policy that would govern promotions, but for the sake of illustration, we would like to indicate how it might work. The following features could be a part of such a scheme :

Attending CME programmes, organised by professional bodies. Completing a web-based feedback form or a professional periodical based feed back form that is filled in after studying the concerned section or sections - a sort of questionnaire- but there is no pass and fail- only a proof of having read it. ... Completing a web-based feedback form or special CME publication based feed back form that is filled in and sent after completing reading the concerned publication. This could cover topics like the management of immunisation and the cold chain etc. ... attending training workshops, training postings in special clinics (private or public sector) for acquiring skills like specific surgery or doing ultrasound etc. any studies completed./papers published etc. It is possible to evolve a credit based CME system which could be used for promotion policy as well. The CME system would be non-threatening evaluation. Thus there is no one who fails- only a proof needed of their having gone through the course adequately and reached a certain competency- largely open book evaluations on previously announced questions that can be given whenever the person wants to.

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The CME system would be based on non-threatening evaluation. Thus there is no one who fails- only a proof needed of their having gone through the course adequately and reached a certain competency-

The feeling of professional dissatisfaction may be higher especially in postgraduates and needs to be addressed through better professional opportunities. ... As a general principle no postgraduate- especially on the surgical side- should be left without being able to consult/work in his speciality area at least once a week.

- The feeling of professional dissatisfaction may be higher especially in postgraduates and needs to be addressed through better professional opportunities. Perhaps they could be linked to CHCs, which they attend on certain occasions. Thus a surgeon should be able to perform operations on certain days and so on. They should be able to send for investigations at higher centers directly. They should also have access to drugs related to their field of specialisation, which normally we would not expect a PHC doctor to handle. As a general principle no postgraduate- especially on the surgical side- should be left without being able to consult/work in his speciality area at least once a week.

3. Drugs in PHCs

We recommend the following three related changes to improve the drug management system at primary care level.

- The distribution system based on the "pass-book", like the system in Tamilnadu, is urgently needed so that distribution can be uninterrupted all year around and responsive to patterns of usage. In this system each facility has a passbook, which reflects the amount of drugs in stock. When the supply falls to below three months usage - a level fixed at the district level for each drug - then the facility immediately indents for the drug to the district warehouse- which in turn supplies the drug to the PHC in the same week. When the district warehouse stock falls below its three-month figure, the same drug is immediately procured at approved rates.
- The essential drug list should be followed in purchases. A quick process of appeal can be built in where a CMO or director appeals for permission to purchase a drug outside the list- but this must be done only with

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prior permission. Without permission upto 10% of the budget may go to such outside the list purchases at the facility level. Any violation of the essential drug list beyond these two flexibilities should invite disciplinary action – or else it would be difficult to get a meaningful drug policy into place.

- Although the need for such a fair & transparent drug procurement system is acutely felt at various levels, we need to address this as an issue that requires the immediate attention of policy makers.

4. Laboratory Services

Since the number of laboratory technicians is adequate only to man the CHCs a greater effort should be made on multi-skilling other cadre to undertake this work at the sector level. The MPWs male and female, the compounder and in select cases even the dresser and the nurse may be made capable of lab work.

- The basic laboratory set of tests provided at the PHC must include blood haemoglobin estimation, total count, differential counts, bleeding time and clotting time, blood smear examination for parasites, urine examination for albumin, sugar, ketones, bile salts and pigments, and microscopy of urine, sputum acid fast microscopy, grams staining of sputum and CSF and stool microscopic examination for ova and cysts and hanging drop examination of stools. The sickling test must also be considered.

- This set of tests can be taught to a team member – primarily by the medical officer. Training programmes at the district level would supplement this. The medical officer would only need a one week package to be refreshed on laboratory work if there is a good text to follow along with teaching materials organised well.

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The basic laboratory set of tests provided at the PHC must include blood haemoglobin estimation, total count, differential counts, bleeding time and clotting time, blood smear examination for parasites, urine examination for albumin, sugar ketones, bile salts and pigments, and microscopy of urine, sputum acid fast microscopy, grams staining of sputum and Csf, and stool microscopic examination for ova and cysts and hanging drop examination of stools. The sickling test must also be considered.

The importance of a referral system between the PHC and the CHC cannot be over emphasised. Broadly, the following reasons necessitate the need for a good referral system:

- Charts and guidebooks that both doctors and multi-skilled staff can refer to along with pictures of microscopic appearances should also be available in every centre and their absence is a serious remediable problem.

5. Referral System

The importance of a referral system between the PHC and the CHC cannot be over emphasised. Broadly, the following reasons necessitate the need for a good referral system:

- a. For establishing the diagnosis for which laboratory investigation is not available at the PHC.
- b. For establishing the diagnosis for which a second opinion or an expert opinion is not available in the PHC.
- c. For management of a case whose diagnosis is known and infrastructure, staff, equipment is adequate but for whom drugs are available only at the next level e.g. epilepsy.
- d. For management of a case whose diagnosis is known but where the quality of equipment or infrastructure or staff is needed in the PHC- e.g. All in-hospital care or surgical care etc.

Under condition a & b, the referral is a one time event and with good quality and prompt feedback, the case can be further managed at the PHC level.

Condition 'c' is avoidable and requires that the drugs be available at the PHC. The new essential drug list has a number of drugs included in the primary health centre list so as to avoid such referrals altogether – this is relevant to primary care for most non communicable diseases. Once referral for conditions a and b are in place the need for avoiding referral 'c' would be even more urgent. We would however, always have some diseases ,which

In our situation of illiteracy and low schooling and mystification of medical practice, sending a note back with the patient is not a reliable, accountable or effective referral system. In addition to sending the note back with the patient, instructions for follow up should be transmitted through the health system and available for verification.

would come under category 'c' and either special indent of drugs to PHCs should be allowed or they are managed by referrals.

Condition "d" may occur as an emergency or in routine outpatient circumstances. Some of these cases would need to be followed up at the higher level for all time to come. But many could be sent back for follow up to the primary level once the acute crisis is over.

We can thus see that all the above referral purposes need a referral system- the heart of which is the feedback arrangement to the primary level. If such a system is well in place the capabilities of the PHC and the medical officer there are dramatically increased.

In our situation of illiteracy and low schooling and mystification of medical practice, sending a note back with the patient is not a reliable, accountable or effective referral system. In addition to sending the note back with the patient, the feedback data on referred patients- whether it be expert opinion, or laboratory investigation, or instructions for follow up should be transmitted through the health system and available for verification. Eventually this should be electronically transferred through web and WLL systems.

Constructing an effective feedback is therefore the most important aspect of the referral system.

A similar arrangement between PHC and the district hospital directly is also needed where it is known that the required facility is not available at the CHC.

A good transportation/communication system is essential for any referral system to function properly. It should be possible to develop a network of ambulance

Constructing an effective feedback is therefore the most important aspect of the referral system

A good transportation/communication systems is essential for any referral system to function properly. It should be possible to develop a network of ambulance system with the help of local community organisations to transport patients.

A referral system between HSC and PHC and between Mitadin and PHC is also needed. ... The referral fund currently placed at the disposal of panchayats may be operationalized through Mitadinss.

system with the help of local community organisations to transport patients.

A referral system between SC and PHC and between Mitadin and PHC is also needed.

The referral fund currently placed at the disposal of panchayats may be operationalized through Mitadinss. She should be authorised to arrange the required funds for referring needy patients and even accompanying patients to PHC and CHC especially for certain categories of illness – like high risk pregnancy or life threatening emergencies and so on.

6. Inpatient care in PHCs

The goal of institutional deliveries requires a functional labour room and at least four beds with relevant support facilities- toilets, stores etc.

Thus, on geographical and social considerations we envisage three types of PHCs:

- Those with no beds in remote areas with staff and infrastructure problems – an immediate solution but which is meant in the long run to go on to 4 to 6 bed hospitals.
- Those with 4 to 6 beds in most PHCs- aimed for institutional delivery.
- Those with 10 bed PHCs in large and difficult blocks where nonmajor surgical in-hospital care can be made available. The geographical and social diversity of Chhattisgarh requires such a differentiated approach. The location of each of these should be part of the block plan.

The goal of institutional deliveries requires a functional labour room and at least four beds with relevant support facilities- toilets, stores etc.

There is also a need to examine the possibility of establishing such rural hospitals in between the current PHCs and CHCs.

7. On Training (see chapter 9)

We recommend institutionalisation of in-service training with the following features:

- The training policy must specify that every two years at least 15 days of training is given to the MPW and health supervisor (male and female).
- A roster of all MPWs and health supervisors should be maintained at the block and district level just for this purpose denoting last trainings attended topics and number of days of training in each. The block medical officers may coordinate with district training centre to see that all their health workers have received the mandatory training.
- The syllabus for it should be built up to include
 - ◆ Changes in health programme guidelines of national health programmes-best addressed through two day sensitisation programmes- whenever such a change is made.
 - ◆ Renewal of core area of their work – RCH programme for MPWs (at least 15 days) and national programmes for male workers.
 - ◆ Multiskilling training in which female workers learn more about national programmes and about basic laboratory skills and male workers learn about RCH and adequate levels of basic laboratory skills.
 - ◆ Adequate training for first contact curative care.
 - ◆ A modified IEC programme capability. The focus must be on interpersonal and community mobilisation skills along with better understanding of a multicultural and ethnically diverse society.
- The supervisors should be held responsible for on the job training of the health workers. Periodic evaluation of knowledge and skills of health workers be used to ensure

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The supervisors should be held responsible for on - the - job training of the health workers. Periodic evaluation of knowledge and skills of health workers be used to ensure that the supervisors perform this task adequately, as they should be accountable for the level of skills in to their juniors.

that they perform this task adequately, as they should be accountable for the level of skills in to their juniors.

□ A training cell for in-service MPWs and supervisors training needs to be constituted in the SIHFW that is constantly doing training needs assessment, training material development, master trainer training of district training centers, supervision of training rosters and training evaluation.

CASE STUDY

FUNCTIONALITY OF A PHC

The press had reported a few malarial deaths in a tribal area of Kota block. In response a senior team visited the sector PHC in the affected area and we went along.

The sector PHC medical officer Dr. K was a young doctor who had graduated two years back and was now quite dazed by the tension occasioned by the visit of the senior team. From the selection of books on his table he was probably preparing for his PG entrance examinations.

The high incidence of fever and a few related deaths had been noticed over two weeks back and one concerned senior officer had made visits. Dr. K had seen his role as attending to those who came to the outpatient clinic and continued with it. A week back one patient with high fever had come too late and died at the centre. An obvious malarial death – but since no smear was done – not officially so. When he ran out of drugs he had indented for more but as supplies were not prompt nor adequate he had shown initiative in purchasing some chloroquine from locally raised funds- (it had a small RKS fund). Patients with high fever were admitted and the two beds here had been kept occupied. They were on intravenous fluids but quinine was out of stock. Quinine was out of stock even at the time of the visit. The drug cabinet was however full of drugs many of which like multivitamins and nimesulide are costly and not even on the state drug list.

The PHC was a sub-center building converted into a PHC. Staffing in terms of MPWs and supervisors and support staff were numerically adequate but the skills needed – microscopy, nursing care for in patients and epidemic management etc were all absent. Only a day before the microscope had reached the PHC and till then the slides had been sent to the CHC for reporting.

The medical officer had no clue about what action was needed and was not even aware of the basic indicators like API or SPR by which the epidemic could be assessed. These figures had been computed but had been handed by supervisors directly to block- leaving this officer out of the loop. Asked aside what his perception of the problem was he burst out- "there some disgruntled staff, one of whom lost her quarters when we made this a PHC, and one on whom I had been tough. They are out to malign me. It is they who leaked this story to the press!!" Before we left, the panchayat sarpanch presented a petition to the team extolling how duty-conscious the doctor had been – obviously motivated to save the doctor from disciplinary action.(the sword hanging over the doctors head was that he had not been resident in the village till the epidemic broke out). The para-medicals perceptions of causes also exclusively focused on whose failure it was. This same blame-game was also played out at senior district levels. Curiously though everyone was quite aware that it was the other persons failure no one was quite aware as to what exactly they had failed to do.

A rapid massive one day fever survey with radical treatment to all those with fever was planned out as an immediate measure before we left. Follow up measures were also recommended.

Discussion: Everyone knew that the epidemic was there. Most of the physical components of the system are in place. Some components like the drugs and the microscope are not physically there but potentially available. The staff are numerically adequate but the skills are not in place. The good doctor is present but never understood from the beginning when he noticed the fevers to the time of the visit -what he had to do other than attending to the patients in his outpatient clinic. A standard clinicians problem which the system had done nothing to ameliorate. Time and again we notice that though there are hardware problems, it is the software that beats us. Making primary health care work is more than the arithmetic sum of infrastructure and manpower and equipment and supplies. It is also more than blaming the doctor for not going to rural areas or the staff for lack of motivation. These are really design problems. Such systemic problems need systemic solutions.

Chapter - VI

The Community Health Centre



In this chapter we discuss the large gap between the package of services which ought to be available in the CHC and what is in reality available. We then try to evolve some practical steps by which this gap can be closed over a relatively brief period of time. The BMO and the BEE - two key players of the health sector - are also discussed at length.

ADEQUACY OF CHCS

The CHC is conceived as a 30-bed secondary referral centre, the most important component of secondary referral along with the district hospital. The norm expects one CHC per block of about 1.0 lakh population. If we deduct 24 lakhs as the population in the main urban municipal corporations, the current average population per CHC works to about 1.5 lakh. The table-39 indicates the current position.

Table-39 : CHC to population ratios

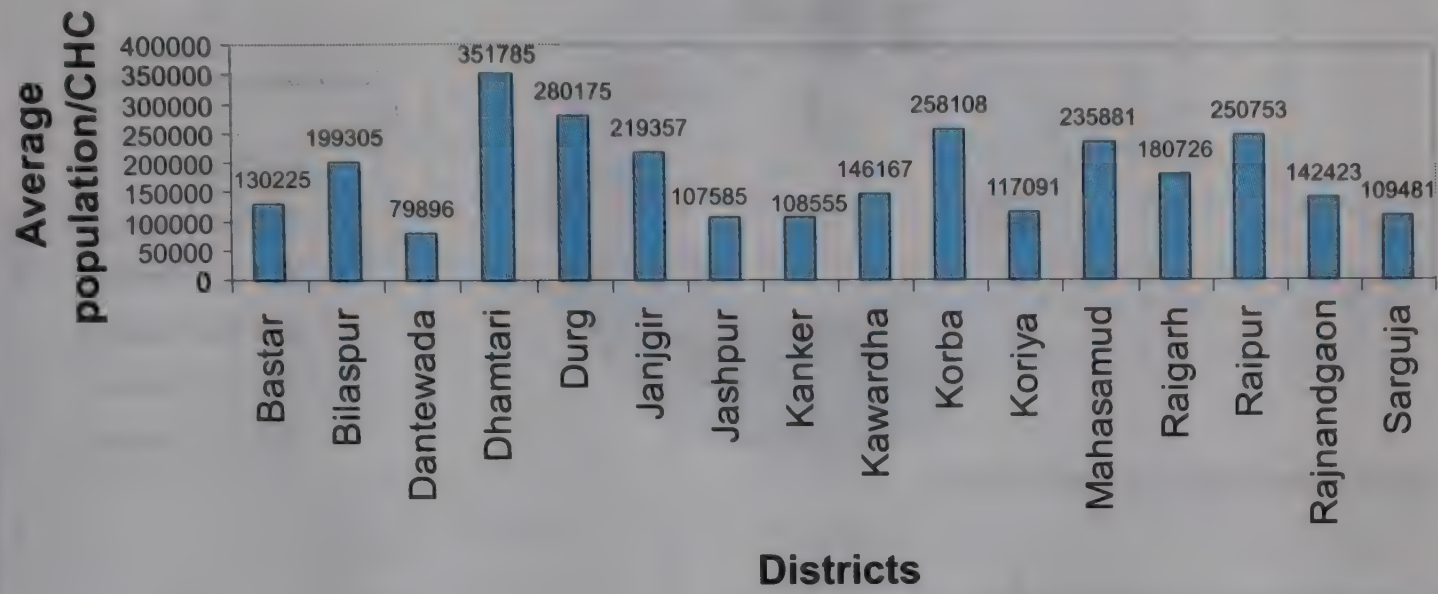
District	Popn. (2001)	Blocks	CHC	Av popn. /CHC	Popn/CHC excluding city
Bastar	1302253	14	10	130225	
Bilaspur*	1993049	10	10	199305	163904
Dantewada	719096	11	9	79896	
Dhamtari	703569	4	2	351785	
Durg*	2801757	12	10	280175	163063
Janjgir*	1316140	09	6	219357	133126
Jashpur	753096	8	7	107585	
Kanker	651333	7	6	108555	
Kawardha	584667	4	4	146167	
Korba*	1032432	5	3	258108	174286
Koriya	585455	5	4	117091	
Mahasamund	943527	05	4	235881	
Raigarh*	1265084	9	7	180726	
Raipur*	3009042	15	12	250753	159869
Rajnandgaon*	1281811	9	9	142423	119979
Sarguja	1970661	19	18	109481	
Total of all 16 districts	#20912972	146	121	152,066	

*Indicates major urban concentration which would explain in part the gap

Source : Secondary Data: Report from districts as available in directorate- June 2003.

(Figure in last col. indicates ratio after excluding major urban agglomerations: Durg 8.45; Bilaspur 3.54, Raipur 6.11; Rajnandgaon 2.02; Korba 1.61. Janjgir 1.18, Jagdalpur 1.08, Raigarh- these are 1991 census figures whereas district's popn figures are 2001)

Figure 11: CHC to population ratios



Source: Secondary data, district reports

We can see that in a number of districts there are blocks, which still do not have even designated CHCs, but these are a small minority. These are prominent in the districts of Bastar and Raipur.

One plausible reason for coverage less than the norm is that these blocks are large geographically, compared to other districts. Since in the case of CHCs the location is decided by it's being parallel to the administrative block, in large blocks the norm is always exceeded. We note that in certain districts the gap appears smaller if we deduct the urban population, which would be served by the district hospital directly. Even then the majority of CHCs cover a population far above the specified norms, which are one CHC for every 1 lakh population and for tribal areas one CHC per 80,000 populations .

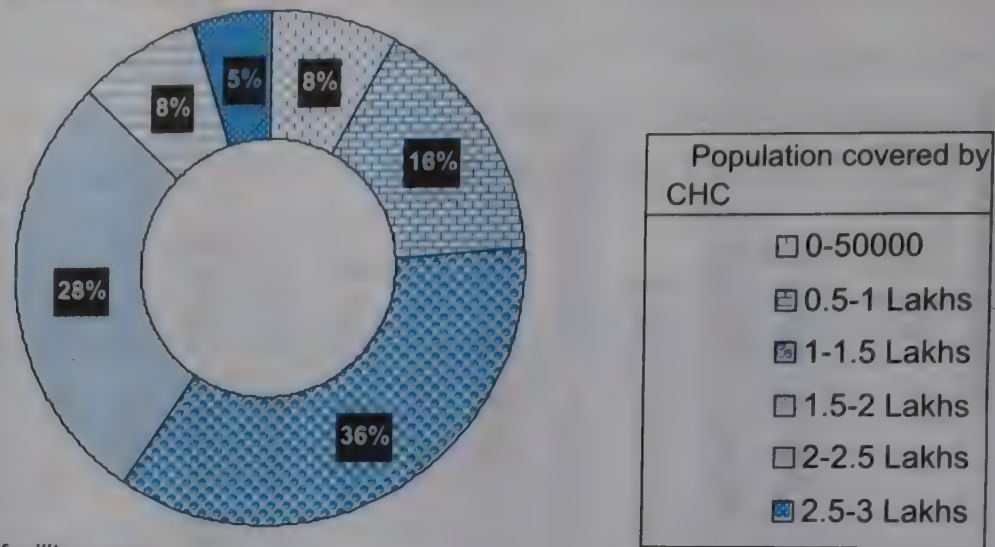
Table-40 : Range of population per CHC

Population Coverage	% of CHCs
0 to 50,000	8
0.5 to 1.0 lakhs	16
1.0 to 1.5 lakhs	36
1.5 to 2.0 lakhs	28
2.0 to 2.5 lakhs	8
2.5 to 3.0 lakhs	4

Source : Primary Data : Facility Survey CHCs

As we noted for PHCs and sub-centres, this often hides a wide variance of coverage between facilities.

Figure 12: CHCs grouped by population serviced



Source: Primary data , CHC facility survey

Table-41 : Range of PHC per CHC

No. of PHCs per CHC	% of CHCs
0 - 3	44
4 - 6	44
7 - 8	12
> 10	0

Source : Primary Data : Facility Survey CHCs

Table-42 : Range of sub-centers per CHC

No of Sub-centers per CHC	% of CHCs
10	12%
10 - 20	36%
20 - 30	32%
30 - 40	12%
40 - 50	8%

Source : Primary Data : Facility Survey CHCs

The number of PHCs per CHC, which is needed for the effectiveness of the CHC's public health functions, varies widely. As many as 44% having a sub critical number. By norms one would expect at least 4 PHCs per CHC, especially in tribal areas.

We also expect, by norms, roughly 20 HSCs per CHC. Here we find that the coverage is adequate and much better than the norms (table 42). This reflects the fact that as the administrative block becomes bigger the number of HSCs continues to rise as they are strictly by population norms. However, the number of CHCs remains fixed at one and the number of PHCs varies arbitrarily. **What is indicated is, that the gaps that need to be closed are essentially in the number of PHCs as well as in having some CHC equivalent facilities within the block if the block is very large.**

Ray Diagram of Distribution of PHCs & HSCs in Block Manendragarh

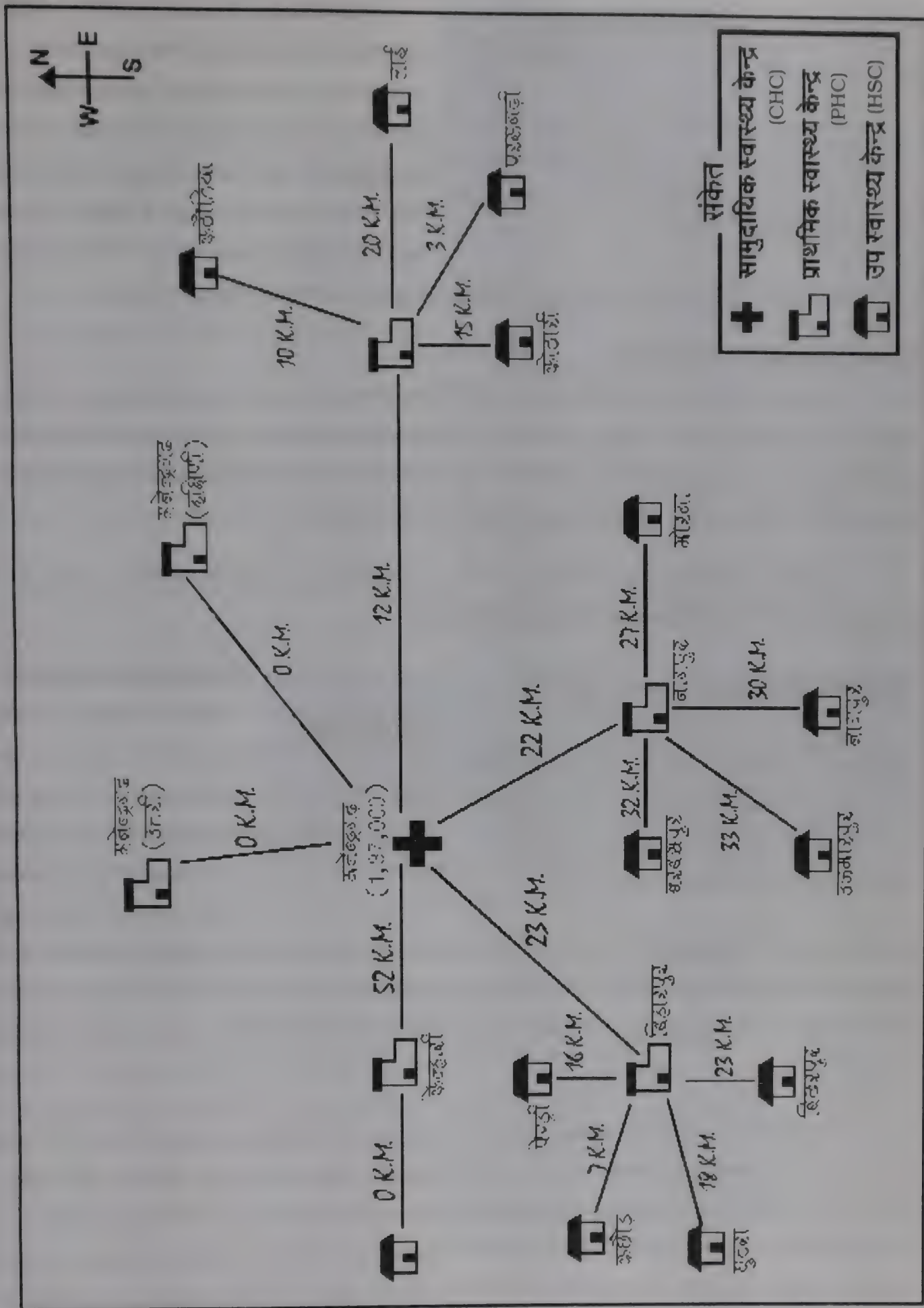


Table-43 : Distances from PHC to CHC

Av. distance range from	PHC to CHC (km)
0 – 10	15%
11 – 20	58%
21 – 30	27%

Source : Primary Data : Facility Survey CHCs

The distances between PHCs and CHC are difficult to capture. Numerically we have expressed the relationship in table 43. But figure 13 is perhaps more indicative of this complexity. An interesting point is that most PHCs are within 1 to 2 hours journey by ambulance from the CHCs – a useful

observation for planning referral and support linkages between these two levels.

PERFORMANCE OF CHCs

In brief, a CHC has two main functions. One is to provide leadership, training and support to all the public health functions in the entire blocks as operationalized through the primary health centers and sub-centers. The other is to provide a good quality of curative care and referral services for the entire population of the block.

In what follows, we first assess the performance of CHCs in these areas and then analyse factors that influence their performance.

Table-44 : Average outpatients per CHC

	Avg. per CHC
a. Total No: who came for ailments over last week	266
b. Total No: of persons who attended last month.	1142
c. Maximum number of patients in any month.	1829 (July/October)

Source : Primary Data: Facility Survey CHCs

Outpatient Services

Most CHCs (83%) had records of outpatient attendance. Our primary survey of CHCs shows an average OPD attendance of 266 cases per week or about

50 cases a day. The range of cases over is from about 45 on the lower side to about 75 per day, at the maximum. Even within this group about 40% of CHCs had an attendance of about 100 patients per day (assuming a 20 day month). The variety of cases seen in CHCs is shown in table 45

In our field visits we visited two CHCs where the attendance approached 200 cases per day and these were well-run CHCs led by dynamic block medical officers. We also visited three NGOs that run secondary care facilities – Shaheed hospital, RK Mission hospital and JSS hospital at Ganiyari. These hospitals share characteristics with CHCs in terms of facilities and staff strength and area of coverage that makes them useful benchmarks for secondary health care. The outpatient care load in all these three NGOs averages about 200 cases a day.

The caseload of tuberculosis and leprosy varied very widely. One fourth of CHCs had no cases of tuberculosis and another fourth had less than ten cases on treatment. Another fourth had about 10 to 50 cases and less than a fourth had over hundred. For a population of a lakh we may expect more than a hundred cases—especially as one has rampant malnutrition in these areas. Case detection is obviously low.

In leprosy, the cases reported could vary from 500 per centre to less than 100 though the average report was 108. In our study, we could not assess the situation with regard to leprosy.

The above data is indicative of disease profile. Certain cautions in interpretation would be in order. Though we have tried to insist on collection of data only from CHCs, which have records, record maintenance has been poor in quality and may have been filled in by recall. Secondly, data of outpatients at the secondary care level is not equivalent to actual disease incidences and prevalence as would be made out from a good epidemiological study. In built system imperfections in disease recognition in the public health system and patterns in the public health seeking behaviour always exclude certain category of diseases. Tuberculosis is already pointed out. Malnutrition is another example. Certain non-communicable diseases like hypertension and epilepsy are also examples. Despite all these limitations this data does give us a glimpse of current curative care,

Table-45 : Disease distribution in CHCs

Case diagnosis	Monthly average per 1000
a. Fever	337
b. Pain	80
c. Diarrhoea	35
d. CVS	13
e. Neuro.	2
f. GIT	19
g. Obs-AN	40
h. Obs-PN	20
i. Gynae	104
j. Eye	45
k. ENT	24
l. Skin	30
m. Psych	18
n. Injury Minor	130
o. Injury Major	13
p. Surgery Minor	20
q. Surgery -Major	23
r. Dental	10
s. Emergency services	34
1 Normal labour	7
2 Obstructed or complicated labour	2
3 Unconsciousness	1
4 Injuries	7
5 Snake bites	2
6 Poisoning	2
7 Surgical emergencies	8
8 Other obs. or gyn. emergencies	3
9 Paed. emergencies	2

Primary Data : Facility Survey CHCs

The urgency of commissioning the burden of disease studies and basic epidemiological work - both completely absent in this state - cannot be overstated. Scientific planning in public health cannot be said to exist in the state unless that task is completed.

which in turn is useful to plan existing services and support for it better.

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In-Patient Care

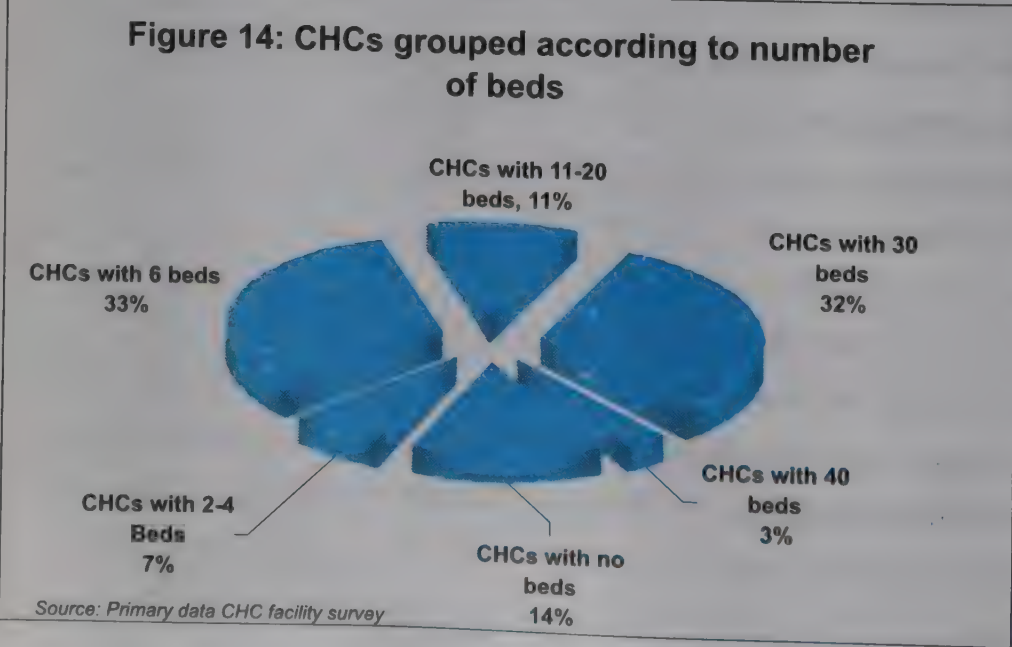
In-patient care occurs in most CHCs and “CHC designates”. The of beds position beds in the CHCs surveyed was as follows :

If we take 10 beds as adequate to provide adequate inpatient care then about half 46% have by this parameter adequate strength to function as a CHC. The rest are merely designated as CHCs, In the sample this study covered, there were an average of 11 admissions per month in the CHCs, which had beds. This is a low occupancy rate.

There are four major reasons for admission: fever, deliveries, diarrhoea- vomiting, and injuries in that order of frequency. Most fevers are malaria or suspected malaria though some of them have been diagnosed as typhoid.

On deliveries there are about 1 to 3 per month in most CHCs; and only about 15% had over four cases per month (an average of about one per week).

The range of other diseases noted as reasons for admission included: burns, abscess, hypertension, diabetes, snakebite, poisonings, tuberculosis, hernia and fractures. These were,



however, of very low frequency numbering even when taken together only one or two admissions in each of the CHCs studied. Surgical care is available in a very limited number of CHCs. In our sample of CHCs, only two (7%) reported adequate surgical care.

Quality of care is also a function of cleanliness and how norms on mantaintenance are followed.

Table-46 : Linen use on CHC beds

	% of CHCs with bed strength as follows:	% of CHCs where beds were found Linen covered
CHCs with 1-10 beds	45.83%	81%
CHCs with 11- 20 beds	8.33%	100%
CHCs with 21 –30 beds	37.5%	33%
CHCs with 31 –40 beds	8.33%	0%
Total CHCs with data	100%	58.33%

Source: Primary Data : Facility Survey CHCs

One finding in the survey was that as many as 58.33 % of CHCs are not able to ensure linen on beds and regular change of linen. Some of this is because of non-use of the facility for inpatients. Thus those with more beds had lesser linen coverage reflecting less occupancy. In others it was non-use of linen even if the beds were being occupied. In two of the five CHCs visited by the study team, the bed linen were not in use even though there were patients. Linen was available and “kept safe.” There is a mindset about inpatient care in the public health system very different from the mindset for the same care in the private sector.

ADEQUACY OF CHC STAFF

The medical staff strength overall and specialists’ capabilities available at each CHC are important for its functioning. Of the CHCs studied, most did have the necessary strength in numbers- though not of specialists as required. Thus only 45% of CHCs had specialists though all had medical officers. The distribution of medical strength is as shown in table - 47. It shows a large variation.

Table-47 : Range of doctors per CHC

No of doctors per CHC	
1 to 2	18.18 %
3 to 5	54.54 %
6 to 7	18.18 %
8 to 10	9.09 %

Source : Primary Data : Facility Survey CHCs

Specialist Gaps

The norm is that each CHC should have a skill mix of the four core specialisations – surgery, obstetrics and gynaecology, general medicine, and paediatric. The current proposal of doing this is for posting two doctors of specialist cadre and two of the medical officer cadre – Those medical officers with PG qualification are called PGMO and informally they are treated as a cadre for preferential posting in CHCs.

If we look at the skill-mix actually available we find that it is highly variable. The attempt has been in some districts to have a surgeon (including orthopaedics) or gynaecologist in as many as possible CHC and a physician and paediatrician also in the other CHCs. In other districts some CHCs have been chosen for a surgeon- gynec combination so that some surgery- capable CHCs are developed and others are combinations of the other specialists. The shortage of specialists is both due to an absolute lack of availability as well as any special efforts to recruit those available by offering special packages. The latter is because of the lack of flexibility government services seldom have.

We also note that there is a high degree of maldistribution of specialists amongst the facilities. Many qualified surgeons, gynaecologists, orthopaedecians, anaesthetists, languish in PHCs and or CHCs that have no surgery capabilities, while well-equipped operation theatres remain vacant for lack of specialists. But table- 48 shows us that part of the problem is created by mismanagement. In almost every category we see that there are qualified PGMOs often

Table-48 : Specialist Posts As Compared to Total Number of Qualified Doctors Available in Services

Sl. No	Speciality	Specialists			PG qualified persons Available in Govt. Services
		Sanctioned Posts	Working	Vacant	
1	Medicine	48	31	17	57
2	Surgery	41	31	10	45
3	Paediatrics	45	29	16	77
4	Gynaecology	53	34	19	57
5	Anaesthesia	9	5	4	48
6	Ophthalmology	10	11	-1	51
7	Radiology	6	4	2	28
8	Pathology	6	4	2	38
9	ENT	6	6	0	44
10	Orthopaedics	6	4	2	66
11	Psychiatry	16	0	16	-
12	TB	3	5	-2	42
15	Dental	6	2	4	-
14	Dermatology	3	0	3	0
15	Physiotherapy	1	0	1	0
16	PSM	-	-	-	6
17	Forensic Medicine	-	-	-	2
	Total	259	166	93	523

Source : Secondary data; Directorate of Health Services

posted in PHCs while specialists posts remain vacant. The failure to promote the PGMOs into specialists posts and/or use them according to their qualifications is an example of avoidable wastage. The specialist position is given in table - 48

We also note that 60% of CHCs studied had at least one female doctor in place. Given present ratios, addressing the gender gap at the medical officer and specialist levels will remain a major challenge.

We note that the number of specialists currently being produced by existing medical educational institutions in this state is grossly inadequate to meet the requirements. There is only one medical college in the state that offers postgraduate courses and no other can be expected to reach this capability by the end of this decade even in the best-case scenario.

For example, there are only five anaesthetists graduating per year in the state. And there are only about 14 in service. The requirement at three per district hospital and one per CHC would still work out to almost 200. For emergency obstetric care, a major public health goal that must be realised within the decade, an alternative route of generating specialist skills must be found. The current effort in the state is therefore, to train general duty medical officers with a basic anaesthesia-training course of three months and deploy them in the CHCs so that surgery capability is ensured. The first batch of 9 such basic anaesthetists has completed their course in AIIMS on a special syllabus.

This same problem that is being felt most acutely among anaesthetists extends to almost all specialities. The informal attempts to rationalise the use of existing specialists do not go far. If major public health goals like reduction in maternal morbidity or reducing preventable blindness have to be met or if basic curative care access has to be provided for the poor, then the system, has to show a viable road map to closing this gap. This would need some imaginative and innovative thinking.

Specialist Equipment Mismatches

There is also considerable specialist- equipment – infrastructure mismatch. Thus one CHC would have a gynaecologist but no operation theatre whereas another would have a functional operation theatre but no surgeon or gynaecologist. We have not quantified this in our study. A similar study done by NCAER for the Planning Commission has this data shown in table-49.

Table-49 : CHC mismatches- all India sample study n=36

Mismatches	Total Proportion
OT without specialist	19.4
OT without anaesthetist	66.7
Specialist without OT	8.3
Vehicle without driver	8.3
Driver without vehicle	8.3
X-ray machine without radiologist	16.7
Lab without lab tech	5.6
ECG without trained tech	16.7
ECG without paper	11.1
X-ray machine without plates	2.8

Source : Secondary Data : WFM options and Infrastructure Rationalisation of Primary Health Care. NCAER study Planning Commission, June 2003.

ADEQUACY OF CHC INFRASTRUCTURE

All CHCs are in buildings owned by the government. There is an active programme of building new 30-bedded hospitals. Several of them have already become functional. The primary data show, that 50% of CHCs have less than ten beds and in effect are only CHCs in name. Functionally, they are more like PHCs.

Power supply is not a problem in most CHCs studied. Those that do have a problem all have generators as back up.

Absolute non-availability of water is not a problem. However, inadequacy of a water supply system is a problem and only 20% have running tap water connected to a central overhead tank as would be mandatory for a 30 bedded hospital. At present, water drawn from hand pumps and wells is being used.

At present more than 50% of CHCs do not have telephone access and none of them have a functional Internet access.

Yet another infrastructural aspect, which is also a systems issue in CHCs, is the waste disposal system. Only 18% report any systematic attempt at using landfills or deep burial and less than one fourth have incinerators. Only one fourth reported any use of colour coding for segregation of wastes and even this may be over-reporting. We did not see any CHC practicing this in our field visits to CHCs. Obviously; these are quality aspects that the health management system has just not got around to addressing.

18 of 20 CHCs had functional toilets for patients, though only 9 had separate toilets for staff. Bathrooms, important in an in-hospital facility, were there in only 52%. All these facilities were considered in fair or poor condition – almost none being labelled good.

Almost all CHCs (92.5%) have accomodation as far as doctors were concerned. About 70% had nurses' quarters, 52%had some paramedical quarters, 70% had some quarters occupied

by clerical staff and 37% had some quarters occupied by class 4 staff.

However, most medical or paramedical staffs are not able to avail quarters, as within each category there is not enough for every staff member.

LABORATORY SERVICES

The tests which are being done in CHCs and the approximate number of cases done per test per month, in those CHCs where the test is available, is shown in table-59

Table-50 : Laboratory services

Speciality	Sample	Test	% of CHCs reporting availability of this diagnostic	Approx cases. last month per centre where available
Pathology	Blood	1. Hb %, TLC, DLC, ESR	66.67%	48.71
		2. Blood smear for malaria,	90.47%	363/1058
		3. Blood smear for type of anaemia	<10%	250
		4. BT/CT	4.5	2
		5. Blood grouping, Rh & cross matching	9%	-
	Urine	5. Routine (sugar and albumin & microscopy)	81%	52.38
		6. Bile salts and bile pigment	0	0
	Stool	7. Parasites-Ova/cyst& Occult blood	13.63%	8
		8. Hanging drop (V cholera)	0	0
Biochem	Blood	9. Blood sugar	4.5%	12
		10. Blood urea	0	0
		11. Serum bilirubin	0	0
		12. Other Liver function tests	0	0
	Water	13. Residual chlorine/other chemical	4.5%	0
Microbio	Sputum	14. AFB	72.72%	32.93
	CSF	15. Gram stain/microscopy	0	0
Serology	Blood	16. VDRL	9%	15
		17. Pregnancy test	27.27%	12.33
		18. Widal	9%	6
		19. Hepatitis B Antigen	0	0

Source : Primary Data : Facility Survey CHCs

We find that the most common test is the blood smear examination for malarial parasites and the next most common test is urine tests, the third most common test is sputum for AFB examination, and the fourth most commonly available test is a basic blood test for haemoglobin. All the rest are done in low frequency or not at all.

Sickling test is not available in any of the CHCs visited/surveyed.

The implications of these findings for the quality of care are considerable.

On the one hand we can see that the emphasis of blood smear examination and sputum testing is present as a result of a lot of the two main vertical disease control programmes – on malaria and on tuberculosis.

The other two tests done frequently are also subcentre and primary health centre level tests where they are either unavailable or very infrequently done. Thus CHCs are in many areas providing the level of care that PHCs and sub-centers are meant for and not providing the level of care that CHCs are meant for. In active CHCs we find a high number of blood smear examinations for malarial parasite being done. Thus, we have an average of 343 Blood Smear Examination for malarial parasite (BSEs) per CHC. In the best 10 % of CHCs, we had over 1000 smears being examined monthly and in another 10 % of CHCs we found 500 to 1000 BSEs being done.

If we estimate that it takes about 15 mins for one good BSE, we get an estimate of about 30 BSEs per day or about 600 to 800 BSEs per month. In those 4 CHCs that are doing this many tests the laboratory technician would have a time problem managing any more tests per day. Sputum testing also takes the same amount of time. This overload in active CHCs is because most BSEs are done only at the block level currently and they have to do the examination for the whole block and the slides from all its subcenters and PHCs. Indeed, if we actually manage to get BSEs done in even 50% of all fever cases in a block in season it would be impossible for the CHC to cope with it. No doubt this becomes a justification for the laboratory technician to do what one can and overlook the rest. We also note that as a result the time taken for examination and reporting of a BSE has lengthened to a period where it is no longer meaningful to do the examination at all. Currently most workers report anything from two weeks to a month as the time it takes from smear being taken to report being received by the patient. Indeed most often no report is received. Out of 25,395 blood smears sent in 24 CHCs, a report was sent back only in 9887 cases (38%)!

We have benchmarks from three important NGO secondary hospitals: Shaheed hospital, RK Mission hospital at Narainpur and the JSS hospital at Ganiyari to show that such tests are cost effective and relatively easy to plan for part cost recovery also at this level.

All of them are able to get BSEs for malarial parasites reported the same day and where they have a CHW worker programme they are able to send information to the patient within 24 hours. We know also that most private practitioners do use the entire range of tests.

Similarly the X-ray and the ECG and the ultrasound are three technologies that are available in most CHCs but often under utilised even though there is a X-ray technician available in most CHCs where the X-ray machine is available.

Profile of the laboratory technician

All CHCs are dependent on the staff designated laboratory technician for their laboratory services. We had interviewed 26 laboratory technicians to get a better understanding of this staff category. Their data is as follows:

One can see (from table-52) that most of the technicians have passed high school. They also have an odd assortment of laboratory diplomas that do not necessarily qualify them for this job. On discussion, the ability to perform many of tests in the above list was not acquired as part of their pre service training. Even the tests they currently do such as sputum AFB and BSE for malarial parasite was really learnt on the job or with in-service training.

In-service training has been, especially in recent times, of a very brief duration and

Table-51 : Age & Sex distribution of Laboratory Technician In percentages (n=26)

Age	Male	Female	Total
20 - 25		4	4
25 - 30	4		4
30 - 40	35		35
40 - 50	27		27
50 - 60	30		30
Total	96	4	100

Primary Data : O& M study: Laboratory Technicians

Table-52 : Educational Qualification of Lab Tech (n=26)

Educational qualification	No of Lab Tech
Matriculation	1
10+12 th	18
Graduate	3
Post graduate	3

Technical Qualification: Diploma in medical laboratory technician 7, pharmacist 1 malaria.microscopy1, pathology diploma 3, paramedical 1.

Source : Primary Data : O& M study: Laboratory Technicians

Table-53 : Distribution of in service trainings achieved by year and topic of training

Trainings	Lab Tech trained since 2000	Lab Tech training's since 1994 - 2000
Malaria	8 (3 days training)	4 (45 training)
Pathology		
Malaria microscopy		
Microscopy		1 (45 days)
IPP6		1 (7 days)
RCH		1 (10 days)
Drug reaction		1 (21 days)
TB (RNTCP)	9 (3-10 days)	2 (7 days)
Aids		1 (7 days)
Leprosy	1 (2 days)	
Paramedical	1 (3 days)	
X - ray technician	4 (1 month)	

Source : Primary Data : O& M study: Laboratory Technicians

focuses on tuberculosis or malaria and is not aimed to equip them for other tests. Many are not trained at all, while same persons may have attended one or more than one training.

To many laboratory technicians even the recognition that their job involves doing a variety of at least 30 to 50 tests is fading away

and many do not seem to remember beyond BSE for Malarial parasites and sputum AFB.

A few laboratory technicians, interestingly, have been multi-skilled with training as X-ray technician. The need for laboratory services is well known. The current nature of laboratory services has the following implications:

- ◆ Diagnosis in many cases just cannot be made without the laboratory. For example about 10% of anaemia in tribal populations – or even higher is due to sickle cell disease. We can make a safe presumption that all these cases are being treated empirically for iron deficiency anaemia till they are recognised in a sickling crisis.
- ◆ A number of diseases that can be treated with much better accuracy are now being managed on broad empirical grounds thus causing over use and wastage of drugs on the one hand and frequently inadequate treatment or wrong treatment on the other. Thus CSF examination would never be done making treatment in a number of cases like meningitis inadequate. Sometimes diagnosis for tuberculosis is also missed.
- ◆ A number of cases, which can be treated at this level, are being referred unnecessarily- diabetic emergencies for example or blood transfusion.
- ◆ There is under-utilisation and inefficient deployment of salaried manpower.

Table-54 : Average Monthly Laboratory Tests in Secondary(non- for-profit) Health Sector

Ramakrishna Mission 30 bedded hospital at Narainpur; Bastar dt. Average Daily OPD attendance : 150 patients.					
Sl. No.	Name of Test (Hematology)	Average no. of tests done monthly	Sl. No.	Name of Test Biochemistry / Serology	Average no. of tests done monthly
1	Hemoglobin	204	10	Blood Sugar	45
2	Total Count	105	11	Urea	25
3	Differential Count	59	12	Creatinine	25
4	ESR	65	13	Bilirubin	6
5	Sickling Test	26	14	Liver Enzymes	4
6	Mantoux test	12	15	Electrolytes	2
7	Bleeding & Clotting Time	2	16	Serum Proteins	2
8	Blood Grouping	143	17	Widal	14
9	Blood Cross Matching	28	18	ASO	6
			19	Rheumatoid Factor 7	
			20	VDRL	54
			21	Hepatitis B antigen	29
Shaheed Hospital; Dilli Rajhara:Durg dt. Average daily attendance : 200					
Total monthly blood tests		1403	Total tests done for sickling		361
Total Monthly urine tests done		645	Total monthly sickling positive cases		32.3 (8.94%)

- ◆ A culture of scientific practice is not established and the quality of care would be perceived by the people as less than what is available in the private sector, and on par with-the-treatment-given with the informal private sector.

We give in table-54 the usage of laboratory services for some not-for-profit secondary level rural hospitals, which have less 128staff than the CHC– just for a comparison of the probable need for such facilities.

There seems to be considerable room for fresh thinking and basic planning for laboratory services within the public health system.

Table-55 : Equipment availability (in working order) in CHCs

Item	% of CHCs who have the equipment specified below:
I. X-rays-	
1. 300 mA X-ray	8
2. 100 mA X-ray	8
3. 60 mA X-ray	44
4. Dental X-ray	0
5. Any X-ray	60
II. Electro medical equipment	
1. ECG	36
2. Emergency resuscitation kit	12
3. Boyle's apparatus	20
III. Pneumatic, Hydraulic and sterilisation	
1. Dental unit	8
2. Dental chair	8
3. Operation table	56
4. Operation table (hydraulic)	48
Neither of the above	28
5. Autoclave table (H)	8
6. Autoclave HP (V)	48
7. OT lights (shadow less)	76
8. Suction apparatus (electrical)	76
9. Foot operated suction apparatus	52
10. Vacuum extractors	12
11. Instrument sterilizers	80
13. Gynae electric cautery	8
IV. Laboratory Equipment	
1. Microscopes	100
2. Chemical balance	20
3. Photo electric calorimeter	12
4. Glucometer	4
5. Water bath	4
6. Hot air oven	28
7. Centrifuge	52
8. Counting chamber	28
9. Haemoglobinometer	72

5. EQUIPMENT

Below is a detailed report on the equipment situation in the CHCs. The list is not exhaustive:

We need to emphasise that the availability of equipment may be under reported by this study, which is based on the BMO's oral replies. Very often in our field visits to CHCs, we found BMOs unsure about what equipment they had. The list is long and the respondents would often answer without checking the registers. A safe assumption is that though the respondent may not know whether such equipment is lying in the stores, they would know it to be available if they were using it. The second caution is that the presence of the equipment in no way implies its use. In none of the CHCs, were ECGs being used. In two, equipment had not been unpacked yet. A lot of the items of equipment are redundant even when many of them felt the need for more equipment in other items.

Some of the equipment are not costly but need constant replacement—like the BP apparatus for example or the Ambu's bag or a weighing machine or the counting chamber or the hemoglobinometer etc. These were all originally supplied and somewhere over the years they broke or wore out and were

not promptly replaced. Unless there is a system in place where such items, can be indented and procured immediately, like drugs and consumable, such problems, would remain forever.

Much equipment in use is also sub-optimally used. In most situations, where there is an X-ray, it is being used only for five or six patients a day or even less. X-rays have breakdowns often and this usually takes one to three months to repair. The order has to be placed via the CMO to the directorate who calls on the service engineer who then comes with at least a month or two elapsing. And in one CHC we visited soon after the service/ repairman's visit the machine worked and then broke down again in two days and it took again another two to three months to repair. And all the while the X-ray technician had no other work!!

Drugs

The drugs available in a CHC, especially in categories like antibiotics, appear by BMOs perception to be adequate. However for a number of non-communicable diseases such as hypertension or diabetes or epilepsy the drugs are not adequate.

This broad perception of drug adequacy must be qualified by the actual

Table-55 (continued)

	% of CHCs who have the equipment specified below
10. Time stop watch	20
11. Alarm clock	12
V. Refrigerator and air-conditioning	
1. Refrigerator 165 L	48
2. Refrigerator 300 L	40
3. AC machines with stabilizer	4
4. Water coolers	4
5. Two body mortuary	4
VI Hospital Plants	
1. Generator 5 KV	20
2. Generator 15 KV	8
3. Boiler	24
4. Autoclaves	72
VII. Administration	
2. Computer	0
3. Photocopier	0
4. Fax machine	0
VIII. Surgical Instrument Set	
1. D & C set	60
2. MTP set	40
3. Cervical biopsy	8
4. Delivery set	56
5. Episiotomy	32
6. Caesarean section	8
7. Copper T insertion	80
8. Vasectomy	60
9. Tubectomy	36
10. Suturing tray	44
11. Suture removal	60
12. Venesection	24
13. Incision and drainage	32
14. Appendectomy	8
15. Hydrocoele	16
16. LP tray	12
17. Cauterisation tray	8

Table-55 (continued)	% of CHCs who have the equipment specified below
18. Dental kit	12
IX Other equipment	
2. BP apparatus	80
3. Weighing machine	92
4. Weighing machine for infants	76
5. Infra-red lamps	32
6. Oxygen cylinders	72
7. Nitrogen cylinders	4
8. Regulator and flow-meter for medical gas	36
9. Ambu bag	56
10. Emergency lamps	16
11. Fire extinguisher	20

Source: Primary Data : Facility Survey CHCs

data in stock positions as recorded from stock books.

We observed that for each of the listed drugs a few CHCs at least report nil stock- and this survey was done at a time just after recent purchases. The existing system of drug procurement and management leads to adequate purchase of drugs but not to responsiveness to variations and it leave behind considerable gaps.

It is obvious that the essential drug list has not been seriously implemented. It is also evident that all non-communicable diseases are not

considered as treatable, even at the CHC level. In the absence of a drug like insulin even a common emergency like diabetic ketoacidosis cannot be treated. Also taken along with the frequent perception as stated by medical officers that that there is no problem in drug supply, it is indicative of a situation where the goals have been set very low and where shortages in supplies and lack of services have reinforced one another. Thus patients with complicated labour and patients with diabetes or epilepsy would either get referred away or not come here at all- and the system starts believing that such cases do not exist and facilities for such cases, therefore, are not a priority. (Sickle cell disease is a major example, whereas in the secondary public health system there is a near zero recognition of the problem, it constitutes a major part of the care of all not for profit secondary health centers). In the absence of epidemiological profiling of cases, or the establishment of benchmarks this statement could neither be proven nor disproved.

PERFORMANCE IN SUPERVISION

Other than the curative and referral services discussed above in length, the CHC also has administration, supervision, monitoring, training and support functions for the entire block. Two persons are key to this role. One is the block extension educator and the other is the block medical officer.

We examine their background and roles below.

The Block Extension Educator (BEE)

Twenty-five Block extension educators were interviewed. All but one of them (who was 37 years) was above 40 years of age and 7 of them were above 50 years. Four of them were women including the youngest in this group was a woman. Most of them (10/13), travelled to work in their personal two-wheeler, whereas two used public bus system. Six of them had a basic qualification of school graduation, one was a graduate and 16 were postgraduate. Of this 16 one was an ayurved rattan, another an M. Phil and a third had a diploma in nursing.

Most had been in service for over 20 years and 6 had a service period between 10 and 20. Their service path is varied. Seven began as health assistants and got promoted to BEEs. Six began as social workers and became health assistants and then BEEs. One was an ANM who became an LHV and then a BEE. Two were NMAs and then they NMS and then are officiating as BEEs – not certain about whether they are formally so designated yet. One began as a statistician and one as a junior malaria inspector and one as sanitary inspector and two stated having joined as BEEs.

The majority of BEEs perceived their job responsibility as follows (in order of priority)

- ◆ Supervision of all the staff below them
- ◆ Office assistance especially with the compilation of reports
- ◆ Assistance to organise all sorts of health camps- leprosy, eye camps, LTT camps
- ◆ Health planning. To this we must add, attending to epidemic outbreak, which often takes much of their time.

Extension education work, after which they are named, may be implicit in the above description, but health education is neither stated as such when they are asked about their job responsibility nor does it appear in the data on their work schedule. They are the top supervisors of the paramedical work force and the senior most non-medical personnel. They are the

Table-56 : Educational Qualification of BEE

Educational qualification	% of BEE
10 –12 th	24
Graduate	12
Post graduate	64
Ayurved rattan-1, M Phil-1, Diploma Nursing-1	

Source : Primary Data: O & M survey BEE

Table-57 : Service period distribution of BEE

Sum of services periods (total service period)	% of BEE
10 – 20 yrs	24
20 – 30 yrs	48
> 30 yrs	28
Total respondents	100

Source : Primary Data: O & M survey BEE

Table-58 : Distribution of trainings achieved by year and topic of training.

Trainings	BEE trained since 2000	BEE training's since 1994 - 2000
FP (30 days)	1	
BEE (7 days)		1
IEC (15days)	6	1
RCH (7 days)	4	1
IPP-6		3
Mitanin prerak (7 days)	3	
MPW working training		1
Leprösy (3 days)	1	3

Source : Primary Data: O & M survey BEE

administrative officers in charge next to BMOs in the block. But they are not extension educators. They are therefore doing tasks they are not trained for and not doing what they are in principle (though not in practice) trained for. This contradiction needs to be resolved by re-designation and re-skilling.

The training scenario is similar to the problem with MPWs and health assistants, all cadres, which were created at least in part by merger of uni-purpose workers of earlier

programmes into multipurpose workers. Little training has gone in at the time or after this absorption. Recent training for this group is limited though in the last three years there has been some effort to equip them with RCH and IEC knowledge. About one third of the group we

Table-59 : Training distribution amongst BEE

Who received training in last 3yrs of more than 3 days	Who receive no training in last 10 yrs since 1994	Who received no training at all	Total no trained
17	2	4	19

Source : Primary Data: O & M survey BEE

interviewed had gone to Ahmedabad on training for this aspect. The fact remains that their main job is of supervision and they are ill equipped to do it.

The Block Medical Officer (BMO)

BMO is the administrative head for all personnel in a block. There is no formal designation called block medical officer. This is only a working arrangement. The job carries therefore no stated monetary or service rewards. The chief medical officer at his discretion makes the appointment. The post however carries considerable responsibilities. For a given level of infrastructure, manpower and supplies, their effectiveness is arguably the single "most critical" dimension for determining achievements.

Our data shows all BMOs to be male, with a bimodal age distribution - one peak at 30 to 40 and another at 50 to 60. About half of them stay in campus while others live at varying distances and commute to the place of work. About two thirds of them have undergraduate qualification and a third have postgraduate qualification as well. Over three fourths have been in service for over 10 years. Their service records show relatively more frequent transfers.

The BMO has a multi-varied task profile. Our work-study showed a varied picture. By adding up all their working days and then reducing it to 100 ideal BMO working days, we got the following picture. Out of 100 BMO-working days (excluding leave) 55 goes to what is described as clinical work largely outpatient and office work. In addition, about 5 of these 55 days have a meeting of supervisors at the block. While another 5 days are given to meetings or reviews of work that does not combine with clinical work. Another 15 days goes on camps (the camps in this period were FP operation, RCH camps and camps for handicapped.). Another 10 would go on tour to sector; sub-centre or field visits, inspections etc, and another 6 days would go for meetings or other work to the district office. The remaining nine days are an assortment that includes training and just office work report preparation etc.

Yet the performance of the team as a whole is what they are accountable for and the critical input for this - training their team does not occur on the job chart of either BMO or BEE. Thus, on a field visit to one CHC (Kota), we got a report that out of 21 subcenters, in all 21 MPWs (F) did IUCD insertion, whereas in the other five blocks we went to in the same district, less than a third of MPWs(F) do the IUCD insertions. The difference was limited to the

Table-60 : Age & Sex distribution of BMO

Age	Male (no females)
20 - 25	5
25 - 30	30
30 - 40	50
40 - 50	15

Source : Primary Data: O & M survey BEE

Table-61 : Educational Qualification of BMO

Educational qualification	% of BMO
Graduate MBBS	65%
Post graduate	35% (MD 2, MS 2, DCH 1, DMRD 1 D Orth DNB 1)

Source : Primary Data: O & M survey BMO

Table-62 : Service period distribution of BMO

Sum of services periods (Total service period)	% of BMO
Less than 2 yrs	0
2 - 5 yrs	5
5 - 10 yrs	25
10 - 20 yrs	50
20 - 30 yrs	20
> 30 yrs	10

Source : Primary Data: O & M survey BMO

Table-63 : What is critical to improved Block Performance

S.No.	Services	Priority
1	Improved Lab. And Support Services	17%
2	Better drugs and supplies	11%
3	Economic & administrative freedom	72%

Source : Primary Data: O & M survey BMO

noticed that the ANMs were either not trained or not confident to do this task. Even where they had noticed, the BMO could not train them himself nor could get the training organised

Table-64 : Perceptions of Requirement of Training

	Ranking
1 Standard Treatment Guidelines	4
2 Laboratory technique	5
3 IEC	5
4 Administration	1
5 Surgery	3
6 Counselling skills	2

Source : Primary Data: O & M survey BMO

through an LHV – and was waiting to send the ANMs to the district hospital or a training programme when the time came.

This example is cited because it is typical of much of what can be remedied even within existing constraints in the system. The BMO is more than a supervisor, he has to provide training and leadership. It is his initiative not merely an ability to follow orders, on which the health of the system depends.

BMOs perceptions

Do BMOs perceive themselves as the team leaders? What do they see as the main gaps? What is their attitude and under what motivational and organisational climate do they work? We tried to assess this by using structured questionnaires and focal interviews.

Most BMOs do perceive their role as critical. But simultaneously see themselves as crippled by lack of adequate administrative and financial powers as well as by the lack of any

Table-65 : Best way of upgrading skills as perceived by BMOs

1	Through CME programmes	4
2	Monthly magazine on health dept.	5
3	Standard treatment guidelines	2
4	Regular meeting with seniors	3
5	Training for special skills	1

appropriate incentive to take on this task seriously. Further, they do not perceive drug supplies or lack of laboratory services as major problems, thought they are problems lower in the priority list. This is expressed in table- 63.

This understanding is also reflected in their response to training needs (Table- 64). Most of

them do rate training in administration as their first priority testifying to both their self-image as administrators and their appreciation of the need to develop their skills in this area. Counselling and communication with patients is also seen as the major area for training inputs – which goes along with the understanding that what ails the system is the inability to make people understand. Surgical Training is seen as third in priority and next to this enhancing clinical decision making skills. The need for training in laboratory services and IEC rank low. These are two ends of the spectrum of skills. One is the need for sociological understanding, which is at the heart of IEC and better public health, and the other is the need for laboratory services, which are key to improving quality of clinical services. Both are inadequately appreciated and may not even have been mentioned if they did not appear on the questionnaire.

Asked to choose between different approaches to training medical officers the ranking list showed specific skills training programmes as most sought after and relatively less stringent options like a monthly CME periodical as little sought after. (table- 65)

However, the clearest stated view on the job expressed repeatedly in focal group discussions is a reluctance to take on this job- since it carries no benefits, but has a tremendous increase in work and in risks of disciplinary action, of black marks in one's career and so on. Indeed the problems are so heavy that few volunteer and most have to be persuaded to take on this job. And this situation acts as an incentive for persons with interests "other than health care" to opt for and remain as BMOs whilst better staff opt out.

The total number of CHCs should be as per population norms and not by administrative blocks. This means that the total aimed for should about 180 CHCs. Since there are 146 blocks, we estimate that about 34 intermediate facilities, which we call 'upgraded PHCs' or mini-CHCs, are immediately required. Over time even these should become full-fledged CHCs.

Each such upgraded PHC may be equipped with 6 to 10 beds, an ambulance and more medical officers to achieve a 24-hour medical coverage.

At the level of the block ensuring bed occupancy of these 30 beds is itself a challenge and therefore the attempt to take on 100 bed rural hospitals is ill advised.

Recommendations for the CHC

On Adequacy of CHCs

- ◆ Blocks that do not have a CHC should be sanctioned one on priority basis. There are very few blocks without a CHC but even then this needs to be flagged, so that later planning takes this into account.
- ◆ The service norms at CHCs should be widely publicised among various personnel including members of the Rogi Kalyan Samiti, and to the Mitnin, and peripheral health workers. They should also be informed about what is presently available. (See annexure 2 for service norms)
- ◆ In large blocks with population over 1,00,000 or where geographic problems seriously compromise access to the CHC for some sections, one of the PHCs may be upgraded. The total number of CHCs should be as per population norms and not by administrative blocks. This means that the total aimed for should about 180 CHCs. Since there are 146 blocks, we estimate that about 34 intermediate facilities, which we call upgraded PHCs or mini-CHCs, required for. Over time even these should become full-fledged CHCs. Each such upgraded PHC may be equipped with 6 to 10 beds, an ambulance and more medical officers to achieve a 24-hour medical coverage. These would be in between CHCs, and PHCs. They differ from CHCs in that they do not aim for major surgical capability, and from PHCs, that they in are 24-hour services and that they provide secondary level hospitalisation care. They also have a vehicle to transport those who need surgery to the CHC.

Infrastructure

- ◆ There is an ongoing effort to build 30-bedded hospitals with a modern operation theatre in every designated CHC. This is welcome effort and deserves to be strengthened. At the level of the block ensuring bed occupancy of there 30 beds is itself a challenge and therefore the attempt to take on 100 bed rural hospitals

is ill advised. Moreover, this would be diverting funds away from this basic goal, which is far from complete.

- ◆ Attention may be given to closing the gaps regarding water supply and power supply and to ensuring that separate toilets for staff as well as bathing facilities for men and women are also in place in each of these structures.
- ◆ Telephones are one of the most immediately remediable problems and some urgency needs to be given to this issue. There is much effort at computerisation at state level and providing computers and web-access with training to use this would enhance monitoring and support capabilities tremendously. It should be possible to prioritise this and within a finite time frame achieve this capability at least for CHCs. Computerisation in the present day is also a culture that may be encouraged.
- ◆ Accommodation : The gaps in accommodation are huge. Providing some staff quarters for a small part of the staff is not adequate and availability of good accommodation on rentals is also limited. The most cost effective long-range option in a block headquarter town may be to encourage property developers with some benefit package to build a set of graded residential apartments. The block is where a number of other department personnel rural development, education etc, need to become operational. It would make sense to go for a combined inter-sectoral housing plan integrated with basic amenities like schools, entertainment, provisions etc. rather than for the health department to go it alone.

Laboratory Services : Primary & Secondary Level

- ◆ There is a need to make a separate plan for a quick improvement in the quality and quality of laboratory services available. That many centers have got used to providing curative services without laboratory support is not a good sign. It not only leads to irrational and wasteful overmedication, it also represents a mindset about quality in curative care, which needs to be addressed. The main components of such a plan for laboratory services may

Telephones are one of the most immediately remediable problems and some urgency needs to be given to this

The gaps in accommodation are huge. ... it would make sense to go for a combined inter-sectoral housing plan integrated with basic amenities like schools, entertainment, provisions etc. rather than for the health department to go it alone.

That many centers have got used to providing curative services without laboratory support is not a good sign. It not only leads to irrational and wasteful overmedication, it also represents a mindset about quality in curative care, which needs to be addressed.

Ensure that the minimal equipment and consumables needed for the sector laboratory esp. the microscope is made available in all sectors. Since this is well within current existing norms this is only a matter of urgent implementation.

be broadly stated as follows :

- Ensure that blood haemoglobin testing and urine testing is done at sub-centre level.
- Ensure that a basic set of laboratory tests are done in all PHCs. These should include:
 - ◆ Blood Haemoglobin, RBC and WBC count, differential WBC count, Bleeding time and clotting time
 - ◆ Urine albumin, sugar and microscopy and for ketones, bile salts and bile pigments
 - ◆ Stool microscopy including hanging drop preparation.
 - ◆ Blood smear examination for malarial and filarial parasite
 - ◆ Sputum for AFB.
 - ◆ Sputum grams stain and CSF grams stain(by the medical officer)
 - ◆ Urine test for pregnancy.
 - ◆ Sickling test on blood.
- Ensure that the minimal equipment and consumables needed for this along with a microscope is made available in all sectors. Since this is well within current existing norms this is only a matter of urgent implementation.
- Ensure that the staffs at the PHC are multi-skilled to be able to do these tests. Medical officers' training should enable them to train PHC staff on the job. A good departmental guidebook for this level of services is available, but it may be brought out in Hindi.
- Ensure that the CHC is able to conduct the following tests :
 - ◆ Basic blood biochemistry, and microscopic studies with grams stain, cerebrospinal, pleural, peritoneal fluid examination, immunological testing esp. for hepatitis, typhoid, AIDS, and syphilis.
 - ◆ That X-ray, ECG and ultrasound be the norm for all CHCs.
 - ◆ Every CHC should also have the capability to

Ensure that the staff at the PHC are multi-skilled to be able to do these tests. Medical officers' training should enable them to train PHC staff on-the-job. A good departmental guidebook for this level of services is available, but it may be brought out in Hindi.

take and send samples for microbiological cultures and histo-pathological studies at the district level where relevant.

- Ensure that the laboratory technicians and the X-ray technicians are trained at the district or regional level to do all the above tests and work under the supervision and guidance and quality control of a suitable district level officer in addition to the block medical officer.
- Ensure that the consumables needed for this are made part of the distribution arrangements as would have to be made for drugs, and
- That most blood smear examination for malaria and sputum examination for AFB move to the PHC freeing the CHC for the wider range of diagnostics indicated above. That is, it should be available not only at the CHC but as a referral service to the entire block. We note that by doing the blood smear examinations at the block instead of sector level the smear taking to report reaching back time reaches anywhere from 15 days to one month – which makes the whole procedure irrelevant clinically.
- Ensure that the CHC has at least two qualified laboratory technicians available. They should be trained to do these tests guided and supported by a district level laboratory expert who can train them on the job. In turn they would provide support to sector level laboratory tasks implemented by multi-skilled laboratory assistants.
- Ensure that in addition, the district level officer is in charge of laboratory quality control- a function that is needed even for the current limited services available.
- Ensure that the training staff are multi-skilled and can meet the tremendous expansion of the laboratory skills needed.
- The possibility of public private partnerships in this area of laboratory services needs to be explored at least at the level of the block. A possibility suggested is to see whether any agency would be able to organise a chain of franchisees at the block and district level, offering a

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A more adequate drugs and supplies procurement and distribution system, which also covers frequently replaceable equipment and laboratory consumables, should be in place.

larger package of diagnostic services. There are several models for such contracts like the contractual arrangements in West Bengal for CT scan systems, which may be used as a template to be built upon.

- Current paramedical courses and laboratory technician courses need to be examined to see whether they are providing the above requirements.

Equipments and Drugs

- ◆ The Essential Drug list needs to be implemented seriously and immediately.
- ◆ A more adequate drugs and supplies procurement and distribution system, which also covers frequently replaceable equipment and laboratory consumables, should be in place. The Tamil Nadu model for this may be studied and adopted. Since there would be much delay in setting it up bit by bit, we could benefit from the expertise already available in these states to do this in a build-operate-transfer mode. Invite them for a three-year period. During this period, they can operate the procurement and distribution system. They can further train all our staff and after establish a system. This system can, later, be transferred to a separate Para statal body or a full time unit under a director.
- ◆ Mismatch between drugs, equipment and medical staff needs to be corrected by making the system driven by requests and annual plans made at the block level, rather than procured above and distributed according to some quota system.

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Medical officers and specialists

Core Administrative Issues : Recruitment, transfers, promotions.

Recruitment of most medical officers and specialists are on an ad hoc basis and they are given contractual appointments. While this has considerably enhanced the filling up of vacancies, contractual appointments cannot in themselves be a system, especially for doctors. The need for regular appointment with a possible career plan is essential.

Most medical officers are demoralised and have negative attitudes to the service and it is possible that this seriously affects the quality of service they provide. The lack of a transfer policy is one of the most important reasons cited. The lack of promotion avenues is another. Their own inability to make a career plan where they can enhance clinical skills or get other promotional or career opportunities later is another problem. In a situation where private practice is allowed, there are considerable opportunities for monetary advance based on enhanced clinical skills, but opportunities for this are limited in most of the states rural areas.

Skill-Mix for the CHC

Getting the correct skill-mix at each level of CHC is another major bottleneck. Having defined a minimum package of services at the CHC as essential to meet public health goals (see annexure 2) one needs to put in place a road map by which the desirable skill mix needed for delivering such a package of services would become a reality. We make the following suggestions in this regard.

- Aim for six medical officers at each CHC, four of whom are specialists and at least two of whom are general duty medical officers. Allow most PGMOs with specialist qualifications to be quickly promoted to specialist posts.
- Trifurcate specialist skills into three broader groups and develop a special plan for each group.

Group 1 skills are the core skills needed as per the norms in every CHC- physician, paediatrician, surgeon and obstetrician.

Group 2 skills are needed at adequate measure at district level and should be available on periodic basis or on call to CHCs. These include ophthalmologist, ENT, dentistry, psychiatrist, orthopaedics, public health expertise, and the four diagnostic Paramedical areas – pathology, microbiology and biochemistry and radiology.

Group 3 are the sub-specialities like cardiology and cardiothoracic surgery which are to be limited to the district hospital.

- Redistribute available skills so that a critical number of group 1 are made available in as many CHCs as possible so that at least one in two or one in three CHCs attain

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Make medical doctor recruitment into a district cadre as for other categories.

However, when they are promoted to specialists grade or class I officer they can opt for a cadre change based on the availability of posts in their category in the district of their choice.

critical manpower to become functional at once and then gradually all other CHCs. Fill in the remaining gaps with multi skilling within related specialities. Also, map private sector, available in each district and enter into public private partnerships where suitable qualifications are available in the private sector and the public system has critical gaps. One can also explore options like allowing the CHC OT to be used by this private sector for payment of requisite charges.

- Redistribute specialists of group 2 so that a critical number (one to four depending on the speciality) are available at each district hospital for each speciality and where not possible to regional referral district hospital (one district hospital amongst three or four- may be upgraded later as postgraduate teaching centres as well.) Thus one may have three ophthalmologists in every district hospital and one of them would visit a CHC at least once in two weeks so that all CHCs have a visiting ophthalmologist. Or every district hospital would have some postgraduate doctor multiskilled in basic pathology and microbiology and biochemistry skills so that these services are available at the district level and they also provide support for lab techs at CHC level. Moreover, from the CHC level itself – samples should be collected and reports relayed back. Where gaps remain one may use multi-skilling both from general duty medical officers or related specialities to handle commonly presenting speciality problems. In case these fail which public –private partnerships may be explored.
- Make medical doctor recruitment into a district cadre as for other categories. However, when they are promoted to specialists grade or class I officer they can opt for a cadre change based on the availability of posts in their category in the district of their choice. Thus, those in difficult districts would get promoted earlier. In districts where there are posts vacant-since no one wants to join there- contractual appointments may be made and these would be eligible for regular selection into any other district when those posts are advertised.

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On the role of the BMO

The BMO should be made a designated post. It should be the entrance point to an administrative cadre.

To become a BMO, one should have a minimum service of 10 years. All current BMOs should complete the three-month distance education course in public health management. And, a locally organised course, in government rules, procedures and regulations, and later perhaps, another programme in epidemiology and health planning or in hospital management.

Their promotional opportunities are into state programme officers, heads of training institutions, chief medical and health officers, and hospital administrators and then the deputy, assistant and joint directors at the state level. Promotions would be only after they have completed the courses.

The government may consider a 25% of the basic as non-practicing allowance in return for fulltime availability to public health goals. But this has to be enforced.

Those who do not want to enter this stream become part of a clinician's cadre as different from an administrative cadre, and would be required to take fewer transfers and would have more opportunity for private practice. It should be a choice between better earnings in private practice with fewer transfers or a better basic salary and more responsibility and recognition in administrative matters. The first ten to fifteen years of service should be in the undifferentiated cadre.

Immediate action points irrespective of decision on cadre policy

Since the creation of a medical administrative stream within is a difficult decision to make, a number of immediate steps are also suggested.

These include

- A three-day induction orientation conducted at state level, every quarter, for all BMOs who are appointed in that quarter. This orientation helps them learn all the basic programmes and the administrative issues that they have to handle.

To become a BMO, one should have a minimum service of 10 years. All current BMOs should complete the three-month distance education course in public health management. And, a locally organised course, in government rules, procedures and regulations, and later another programme in epidemiology and health planning or in hospital management should be made mandatory.

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The development of annual block level plans (with guidance) where the BMO and his team identifies their goals and plan their activities and which marks out the constraints in equipment, and infrastructure should be made mandatory.

- The development of annual block level plan with guidance where the identifies their goals and plans their activities and marks out the constraints in equipment, drugs infrastructure etc for action by the district should be made mandatory BMO and his team
- A provision of a block medical officer honorarium/ allowance if we are able to ensure :
 - ◆ That the tenure is of at least three years.
 - ◆ That this is not seen as an opportunity for generating private earnings – for themselves of for sleaze within the system.
 - ◆ That the BMO assignment is linked to developing and implementing a measured and monitored block level health plan.

These are difficult conditions. Currently, this post is ad hoc and carries a stigma as offering personal opportunities only for those acting as facilitators for systemic corruption. However, as new entrants into this dimension, they are still retrievable. At this stage active support along with some encouragement and a self-declaration form may be adequate to motivated them to be honest and effective.

- Insist on every BMO completing a three-month distance education programme on management aspects- arranged by the state government in collaboration with some institution with expertise in health management. This could be of six modules each with review questions and a self-evaluation programme at the end. It would help them understand all the dimensions of the health system that he or she has to manage as well as understand the basic principles of management itself.
- Empower BMOs with the powers and support (from the CMO and state office) required to effect their block level plans including the provision of an adequate imprest fund and basic modern office support.

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THE ROLE OF PANCHAYATS AND ROGI KALYAN SAMITI

One important area of reform would be to actively involve the janpad panchayat and to activate the rogi kalyan samitis.

The active rogi kalyan samiti members along with the janpad panchayat head and some civil society members nominated jointly by the CHMO and collector may function as a block level health committee. The civil society members chosen may not be from the block but they should have a special commitment to developing the health system and should have a track record of advocacy and contribution towards such a goal.

The rogi kalyan samitis have played a good role in raising funds for the CHCs. There have been individual donors who have donated considerable sums. Renting out premises for allied services- drug stores, STD booths etc have also brought in revenue. What is needed is greater participation in expenditure plans- and making such expenditure part of a larger improvement plan based on quality indicators

Whereas the rogi kalyan samiti would focus only on the CHC, the block level health committee would review the Mitani programme, the referral health services including ambulance services, monitor and facilitate the functioning of the sector PHCs and facilitate the involvement of gram panchayats and civil society institutions in disease control programmes.

The block level health plan should be discussed and finalised in consultation with this forum. This forum may meet every quarter other than an annual full day review to finalise the block health plan.

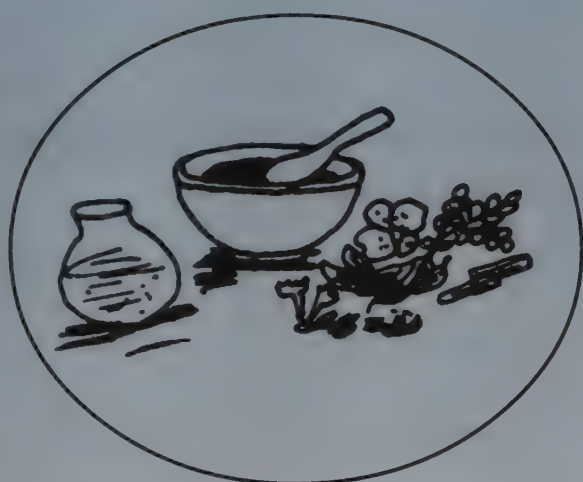
The transfer of resources and administrative control would require a larger political policy change, which is not immediately on the agenda. But considering that there is a constitutional commitment to the same and that the general direction is towards more decentralisation the health sector should begin by taking up work with a number of janpad panchayats, sharing responsibilities with them, building up capabilities and mechanisms of joint functioning and learn from this experience to build up a plan for greater devolution of administrative and planning to the elected local bodies. Thus when the political process arrives at the need for such devolution, decentralisation would take place more effectively and sustainably. On the other hand hasty decentralisation without working out the mechanisms and ensuring that employees are taken along would be ineffective and may be used to discredit the entire process.

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Chapter - VII

The Indigenous Systems of Medicine And Their Integration



In this chapter we note the infrastructure and manpower available under the director of the indigenous systems of medicine and then see what is the functional status of the system. We then look at how this part of the public health system currently contributes to public health goals and make policy recommendations to help its growth in such a direction.

THE STRUCTURE OF THE SYSTEM

Under the rubric of the Indigenous Systems of Medicine are broadly the Ayurvedic & Homeopathic and Unani Medicine facilities. In the state of Chhattisgarh the existing strength of this section at the state level is given below:

1) Directorate

Total sanctioned post (including all cadre of staff)- 41

2) Office of District Ayurvedic Officer

For 16 District – one each

Total sanctioned posts – 15

3) Ayurvedic 30 Bedded Hospital

Total – 6

Total sanctioned posts for 6 hospitals- 132

4) Ayurvedic Dispensary

Total – 632

Total sanctioned staff – 2601 (each dispensary has one medical officer, one compounder, one mahila swasthya karyakarta and one peon and/or one sweeper.)

5) Homeopathic hospitals

Total – 52.

Total sanctioned staff – 208

6) Unani hospitals

Total – 06.

Total sanctioned staff – 26

7) Govt. Ayurvedic Pharmacy Raipur

Total – 01

Total sanctioned staff – 71

8) Govt. Ayurvedic College & Hospital Raipur

Total – 01

Total sanctioned staff is sum of Hospital staff – 83

Office staff – 33

Departmental staff – 97

Table-66 : Sanctioned ISM staff in each district

district	District Ayurvedic officer	Specialist Ayurvedic officer	Ayurvedic Medical officer in dist dispen.	Ayurvedic C Medical Officer in dist hospt.	Assitant Ayurvedic Medical Officer	Female health warker (DAI)
Bastar	1	1	42	-	4	17
Bilaspur	1	1	58	4	4	15
Dantewada	1	-	36	-	-	5
Dhamtari	1	-	26	-	3	1
Durg	1	2	91	3	8	4
Janjgir-champa	1	-	51	1	2	6
Jashpur	1	-	13	-	-	
Kanker	1	-	16	-	-	13
Kavardha	1	-	16	-	1	
Korba	1	-	25	-	1	
Koriya	1	-	13	-	2	
Mahasamund	1	-	30	-	1	1
Raigarh	1	1	19	1	3	
Raipur	1	-	79	5	5	6
Rajnandgaon	1	-	40	-	1	5
Sarguja	1	1	24	2	2	2
Total	16	6	579	16	37	75

Source: Secondary Data : Directorate of ISMs

The distribution of these centres across the districts is remarkable. The infrastructure that these centres command is also considerable though far short of the needs. Out of 690 dispensaries as many 330 have buildings.

The recruitment of doctors and staff has been decentralised to the janpad panchayat but we have no data on how effective this has been.

The entire system has currently no integration at all with the mainstream of public health- except in pulse polio campaign.

The actual number of persons who access it for curative care is also limited- with attendances being low in most places. Detailed figures though, are not available.

Role of ISM facilities in Public Health Goals

There is a strong case for including these centres as part of a comprehensive district plan. There is much they can contribute in all the national health programmes including RCH - and our interviews with both directors and district functionaries show their willingness, even eagerness to undertake programmes like immunisation and family planning.

Today the state has a policy that a BAMS doctor can be appointed in remote areas if there is no MBBS doctor. Also, today a number of irregular practitioners are being certified and three year courses in something as indefinable as alternative medicine is being launched. In such a context the desirability of using the paramedical stream, which is trained, is obvious- especially if we can demonstrate that there is no significant opportunity cost to this. If it has not happened it is merely because the system has not got around to creating such a linkage. This is partly due to a "professional" mindset and should be easily remediable.

Table-67 : The Government's Homeopathic & Unani Facilities

District	Homeopathic medical officer	Assistant homeopathic medical officer	Unani Medical officer
Bastar	1	-	1
Bilaspur	2	7	1
Dantewada	-	2	-
Dhamtari	-	1	-
Durg	1	5	1
Janjgir-champa	-	-	-
Jashpur	1	-	-
Kanker	1	1	-
Kavardha	-	-	-
Korba	1	-	-
Koriya	-	1	-
Mahasamund	-	-	1
Raigarh	1	3	-
Raipur	4	5	1
Rajnandgaon	3	3	-
Sarguja	1	7	1
Total	16	36	6

The specific public health programmes that one can identify for them and their revised work-norms must be worked out in consultation with the section. These could include:

- ◆ Immunisation services
- ◆ Contraception services
- ◆ Child care with focus on nutrition
- ◆ Epidemic Control- focus on diarrhoeal epidemics and malaria control
- ◆ Health camps- especially those which require intensive counselling.
- ◆ Assistance/undertaking Institutional delivery in PHCs in sector
- ◆ Participation in school health programmes

Source : Secondary Data: Directorate of ISMs

Integration would mean working out a commonly agreed set of messages that this system would take forth both to the community in a defined geographic area and to the patients who come to them in search of curative services.

We note that the staff noted as dai under the ISMs have a salary equivalent to the ANM and no clear allocation of tasks other than what the ANM is tasked. But this is not done in a systematic manner. This happens more by default. The medical officers' and assistants' role in public health goals are even less well defined.

Integration on Curative care access

By government policy a BAMS doctor may be posted in a PHC where there is no allopathic doctor. The ISM doctor has therefore been considered an option for appointment in Remote Medically Underserved Areas. Our sample met with one such appointee. There is insufficient evidence to comment on the viability of this proposition. For one, vacancy position in remote areas in the Ayurvedic system is stated to be also high and so is absenteeism. Though there is a vast gap in professional aspiration between the MBBS graduate and the BAMS graduate, the gap is perhaps much less between the MBBS graduate who has to settle for government service and for having been posted in a remote area and the BAMS graduate who is able to secure entry into government service. They too are reported to prefer to keep to urban areas. More data is needed to prove this contention.

The monitoring system is also apparently weaker. Many dispensaries have a good infrastructure building and accommodation facilities but even here the average outpatient attendance is modest.

No quality of care standards or even delineation of the services that a facility ought to provide has been codified. It therefore becomes difficult to comment on whether the facility is optimally functioning or functioning below its optimum. There are no planned periodic training programmes and skill upgradation schedules.

Integration on infrastructure

We note that there are a lot of PHCs without buildings and many sectors without PHCs and a lot of Ayurvedic centres with and without buildings. There is scope for sharing their infrastructure and manpower so that the infrastructure and staff is made optimum use of. In such sharing one must respect the distinct feature of each system and not impose a common curative care regime. But certainly, in public health functions and maintenance and support functions much can be shared.

By integrating the ISM network with the public health programmes a substantial increase in outcomes can be expected at little extra cost,

If in working out areas of coverage of ISM facilities, priority is given to closing the gap between number of sectors and the number of PHCs, then it would be a big step forward. We note that if there is a synergistic deployment of the two- the current gap between number of sectors and the number of PHCs – a sum of about 238 - the single largest gap in the system as identified in this study would be adequately closed by the over 579 rural ISM dispensaries that are functional.

Integration would require a definition of what package of services each category of personnel and facility would provide and based on this a multi-skilling of personnel to serve new roles, new job descriptions and administrative changes to facilitate such synergy.

Recommendations on integration of ISMs

Our prime concern in making these recommendations are :

- A recognition that there is a substantial investment entailed in these systems.
- That utilisation of this investment is extremely low –both in terms of ISM utilisation and in terms of it subserving public health goals.
- That by integrating the ISM network with the public health programmes a substantial income in outcomes can be expected at little extra cost,

To achieve integration we recommend the following measures:

- Mapping out infrastructure facilities of all systems of care in each block. Then in sectors without PHCs the sector team may function from the ISM facility and a doctor may be later made available there – thereby making it a full-fledged PHC. The sector medical officer who would be Ayurvedic or Ayurvedic and allopathic (two doctors) would report to the BMO. In sectors with PHCs, the ISM facility would be given charge of a cluster of villages for paramedical public health functions in addition to their dispensary services. They would report to the BMO with a coordination mechanism with the sector medical officer. If in working out areas of coverage of ISMs, priority is given to closing the gap between number of sectors and the number of PHCs, then it would be a big step forward. We note that if there is a synergistic deployment of the two- the current gap between number of sectors and the number of PHCs – a sum of about 238 - the single largest gap in the system as identified in this study would be adequately closed by the over 579 rural ISM dispensaries that are functional.
- Integration would require a definition of what package of services each category of personnel and facility would provide and based on this a multi-skilling of personnel

to serve new roles, new job descriptions and administrative changes to facilitate such synergy.

- A system/mechanism that at the district level the district Ayurvedic officer serve as part of the health planning committee and this plan is integrated as a subset under the district health plan of the CHMO's office and the district health society.

In addition to integration issues the main problems of administration as identified for the system as a whole are valid for the ISM facilities.

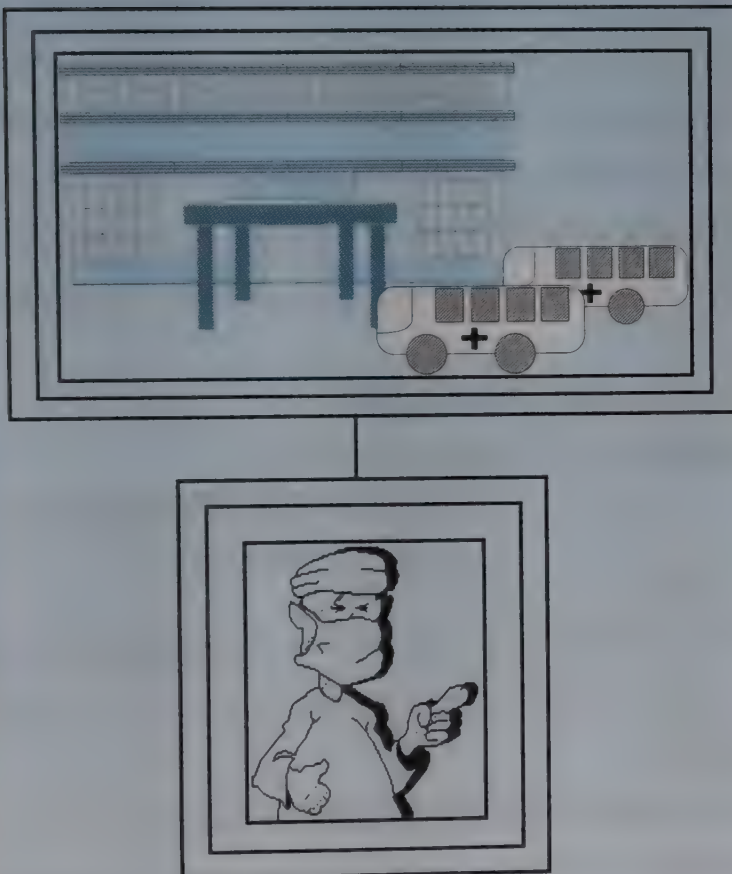
- The Workforce Development programme may in addition to such re-skilling and redefining jobs also look into issues of transfers, promotions and skill upgradation so that they too have a career plan and do not face the denominational factors that the mainstream is already seized with.
- A tighter system of supervision should be developed in coordination with panchayat and the health dept to ensure better attendance and functionality.
- The ISMs may also develop their own drug list, distribution system and training programmes similar to what has been indicated for the PHCs.

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Chapter - VIII

District Level Organisation



This chapter briefly gives the data on district and civil hospitals available in the state, the structure of manpower at the district level and flags some of the key issues that needs to be addressed.

NORMATIVE STRUCTURE AT THE DISTRICT LEVEL

The health administration at district level is mainly looked after by two officers, i.e., the Civil Surgeon & Hospital Superintendent (CS) and the Chief Medical & Health Officer (CMHO). The Civil Surgeon & Hospital Superintendent is mainly responsible for management of district hospital (DH). The CMHO is mainly responsible for management of health care set up in rural areas of the district, which includes Community Health Centres (CHCs), Primary Health Centres (PHCs), and Sub-centres (HSCs), and also the Civil Hospitals (CHs). The CMHO heads the district management team and is supported by District RCH Officer, the District Immunisation Officer, the District Family Welfare Officer, District Malaria Officer, District Leprosy Officer, District Tuberculosis Officer, District Prevention of Blindness Officer, District Public Health Nurse Officer, and District Education and Media Officer. There are also nodal officers assigned for other programmes.

ORGANISATION AND MANAGEMENT AT DISTRICT HOSPITAL LEVEL

As mentioned earlier, the Civil Surgeon-cum-Hospital Superintendent is the head of the District Hospital. His/her responsibilities are usually limited to the district hospitals where he has to look after the hospital administration, and the management of medical curative services and the hospital personnel. Since he is necessarily a clinician, he acts as a clinician as well as the hospital administrator. Traditionally, the Civil Surgeon & Hospital Superintendent has little authority in major administrative and financial decisions. Specialists and medical officers at the hospital usually assist him.

The major thrust areas of hospital management at various levels are:

- | | |
|---|----------------------------------|
| (i) Management of clinical, intermediary, and support services. | |
| (ii) Management of waste. | (iii) Human resource management. |
| (iv) Hospital planning. | (v) Quality management. |
| (vi) Management of information system. | (vii) Evaluation. |

At the district hospital level, the Civil Surgeon-cum-Hospital Superintendent is responsible for these activities, while, the Medical Officer in charge manages at the Civil Hospitals and at the CHC under the leadership of the CMHO.

A scheme that is functional in all districts is the *Rogi Kalyan Samiti*; a registered society. These societies are responsible for the operation of the district hospitals and are authorised to set appropriate user fees. The Civil Surgeon cum Hospital Superintendent at the district hospital, as the executive officer of the society, has full control over the resources generated and their disbursement. Thus, the income generated at government health facilities does not have to be disbursed to the state treasury; it can be used for improving hospital services directly where the income was generated.

Facilities at the district and Civil Hospitals

The numbers of facilities, currently available in this category, are given below :

As we can see many of them have been recently upgraded from civil hospitals or CHCs when new districts were carved out in the new state. The challenge is to now increase their staff strength, infrastructure and equipments to reach district hospital levels.

Table-68 District-wise District and Civil Hospitals in Chhattisgarh

Name of	Name of Hospital	Status in year 2000	Hospital Status as re-designated now	Sanctioned Beds
Bastar	District Hospital, Jagdalpur	District Hospital		269
	RNT Hospital, Kondagaon	Civil Hospital		30
	Civil Hospital, Bhanpuri	Civil Hospital		30
Bilaspur	District Hospital, Bilaspur	District hospital		437
	Civil Hospital, Bilaspur	Civil Hospital		6
Durg	District hospital, Durg	District Hospital		330
	Civil Hospital, Supella	Civil Hospital		30
	Civil Hospital, Bemetara	Civil Hospital		15
Dantewada	CHC, Dantewada	CHC	Dist Hospital	56
Dhamtari	Civil Hospital, Dhamtari	Civil Hospital	Dist Hospital	64
Janjgir	Civil Hospital, Champa	Civil Hospital	Dist Hospital	28
Jashpur	Civil Hospital, Jashpur	Civil Hospital	Dist Hospital	89 (100)
Kanker	Civil Hospital, Kanker	Civil Hospital	Dist Hospital	80 (100)
	Civil Hospital, Pakhanjore	Civil Hospital		50
Korba	Civil Hospital, Korba	Civil Hospital	Dist Hospital	100
Koriya	CHC, Baikunthpur	CHC	Dist Hospital	30
Kawardha	CHC, Sahaspur	CHC	Dist Hospital	30 (100)
Mahasamund	Civil Hospital, Mahasamund	Civil Hospital	Dist Hospital	32
Rajnandgaon	District Hospital, Rajnandgaon	District Hospital		225
	Civil Hospital, Khairagarh	Civil Hospital		30
Raigarh	District Hospital, Raigarh	District Hospital		117
	Civil Hospital, Kharsia	Civil Hospital		36
	Civil Hospital, Sarangarh	Civil Hospital		40
Raipur	District Hospital, Raipur	District Hospital		30
	Civil Hospital, Manna	Civil Hospital		
Sarguja	District Hospital, Sarguja	District Hospital		188
	CRC, Kamleshwarpur	Civil Hospital		20

Table-69 General Profile of District Hospitals in Chhattisgarh

Name of the district Hospital	Year of Establishment	Catchment Area (sq.km.)	Catchment population
DH, Bilaspur	1956	NA	NA
DH, Jagdalpur	1936	210	22,00,000
DH, Durg	1963	200	12,00,000
DH, Rajnandgaon	1997	144	16,00,000
DH, Janjgir	1956	NA	NA
DH, Korba	1987	4258	929629
KG DH, Raigarh	1952	6837	1065939
DH Ragunath, Sarguja	1956	350	20,02,386

Newly created district hospitals are in the new districts of Koriya, Kawardha, Jashpur, Mahasamund, Kanker, Dantewada, and Dhamtari and in Raipur.

The state of facilities is rapidly changing in district hospitals and there has been a lot of progress on this. Yet as many of 9 out of 16 districts

hospitals have not been able to initiate even Caesarean sections and this is an indication of there being a long way to go.

We did not collect primary data on district hospitals equipment, as this was not our focus. Also data of the nine district hospitals that were in existence as of year 2000 is available from an earlier study. This study had looked at staff adequacy, equipment and drug supplies position in all the district hospitals as existed then and we used this data supplemented with discussions with district officials for some broad conclusions.

Broadly, we can conclude that all the problems as stated for the CHC exist but at a higher level. For example, a much larger laboratory service is available here, but histopathology and microbiological cultures are not available. But to serve as referral for the entire block, they must be available. If for every PAP smear or lymph node or bone marrow biopsy one has to go to Raipur then most of the poor have just to decide to give up and go home to die.

We can list the problems of the district hospital under the following heads:

- ♦ Lack of specialists: Acute lack in peripheral specialities- psychiatry, ENT, ophthalmology, anaesthesia, orthopaedics, especially in newly formed district hospitals.
- ♦ Deficiencies in supportive and administrative staff.
- ♦ Lack of equipment in some critical areas though equipment, as a whole is not the critical problem. Poor maintenance agreements and long down times.
- ♦ Mismatch of equipment with manpower and skills available and services delivered.

- ◆ Problems of sanitation and waste disposal.
- ◆ Problems in quality of infrastructure and infrastructure maintenance.
- ◆ Very poor laboratory support – esp. to support specialist work.
- ◆ Ambulance service weak.
- ◆ Blood bank services starting up in most districts but still weak.
- ◆ Hospital administration training for hospital administrator is weak- largely non existent.

PUBLIC HEALTH ORGANISATION AT THE DISTRICT LEVEL

Public health functions as different from the district hospital functions revolve around the Chief Medical Officer assisted by the programme officers.

There are three-sanctioned programme officers' posts at the district level- the district RCH officer, the district immunisation officer and another who looks after the establishment. All these officers are only officiating. In addition there are a number of senior officers who are assigned to look after various key programmes – the district malaria officer, the district tuberculosis officer, the officer in charge of leprosy programmes as well as nodal officers for Mitadin programme, Danida programmes, AIDS control programmes and so on.

None of the programme officers have any induction once they take up an assignment and irrespective as to whether they are designated programme officer or merely holding additional charge -almost all of them are doing their 'programme officer' function as only secondary to their clinical work. There is no induction when they take on a new such allocation and they may and often are summarily removed. Given the lack of tenure and frequent abrupt changing of portfolios and the lack of even a serious job allocation most doctors take up this assignment casually under no pressure to perform. There is a bi monthly programme review at the state level but there is no training for most programmes. There are no guidebooks to help them when they take on a new task.

The Chief medical officer also is officiating in all districts. There is no surety of tenure. The appointments are made by the minister and their tenure rests upon their ability to retain his confidence. There are neither any special qualifications nor training prescribed though most of them are being sent for a two week management training, which could at best sensitise them to the existence of management as a science. There are no induction programmes or reference material and many would move from handling purely clinical assignments to this intensively administrative role without any preparation.

Administrative Functions of the District

The district CHMOs office is also the site of most administrative functions of the health department. Thus personnel related functions- recruitment, seniority, promotions, increments, salary disbursal, leave grant, pensions, provident fund-are all to be managed by this office. Since there are approximately about 2000 personnel in a fair sized district this is a very big task. A shortage of staff and infrastructure to do these tasks in the new districts is a major problem. However, in most districts CHMOs have little or no orientation to these administrative procedures and are completely at sea- dependent on clerical help of very varied and generally inadequate quality.

Similarly, there is no system of warehousing and drugs and supplies distribution in place.

Infrastructure development is also not to any plan or system but case by case.

Thus, in summary, in many districts the administration functions in all aspects on a case-by-case approach. Whenever someone brings to the CHMO's notice that something needs to be done- a pension has to be paid, or a drug has to be purchased, then there is a response. But this would invariably mean that there would be lot of gaps and delays and scope for pressures and inducements. Some CHMOs would be active and therefore would be able to cope, while others would not and do not cope. Workforce morale and service delivery are both affected seriously by such administrative gaps.

The Issue of Decentralisation

The chief medical officers' powers are limited to purchases upto 2 lakhs rupees and some degree of inner district transfers of staff. For the rest, he sees himself as implementing national programmes with RCH as the focus. We need not elaborate further on this. All the limitations pointed out in earlier sections on HSC, PHC and CHC ultimately reflect on the office of the chief medical officer. The question arises as to why problems of logistics, location of facilities, mismatch between equipment and staff were all not preventable or at least remediable at the CHMOs level the immediate authority in charge. This is also the level at which the successful outcomes of any of the national health programmes depend. The district is also the appropriate level of planning and decision-making.

Not surprisingly most CHMOs would attribute most programme and system failures to the lack of powers they enjoy. To some extent the case for decentralisation is irrefutable. However, looking at performance in national programmes even those, which have the

necessary funds and flexibility. We note that there may not be such a direct correlation between powers and outcomes. Motivation and initiative and monitoring may be very highly varied between districts and relate much to the quality of leadership that the CHMO provides. We need to define at how CHMOs are appointed, their tenure, their monitoring, and their training and integrate this into any approach towards decentralisation or even delegation of more powers to CHMOs.

The overall approach to the district public health must remain good block level planning with an empowered block level team

Recommendations for District Level Organization

- Much of what has been said for closing gaps in the CHC and ensuring a minimum set of specialist skills being available apply with even greater urgency to the district hospital. These include recruitment of specialists, continuing education programmes and upgrading skills, multi-skilling available doctors, and public-private partnerships
- Problems of tenure, recruitments, promotions, transfers that relate to adequate staffing of facilities in further districts as well as gaps and mismatches in equipment are dealt with in chapters 10 and 11.
- The issue of decentralisation and increase of powers at the district level is also dealt with in chapters 10 and 11.
- The average district being large and difficult to access and relatively well populated- the overall approach to the district public health must remain good block level planning with an empowered block level team and adequate facilities to handle all referral work at the CHC and only cases requiring a higher technologically demanding specialist or inpatient service being referred to the district hospital.
- A good referral system with the district hospital at the apex is essential. The contours of this have been discussed earlier. At the district hospital level there should be a separate counter and a green line for those who are referred from PHCs or CHCs- even for investigations- so that they are attended to fast – and so that they can be referred back to CHCs and PHCs with an appropriate card- sent through patient (written on the patients referral card) as well as a direct communication through the health system to the referring doctor. This would be easier if digital communications develop but is not difficult to do manually and must be insisted upon. Transport arrangements and consequent cost sharing of it is one related aspect that too has been discussed in chapter 6.

A good referral system as has been discussed earlier, with the district hospital at the apex is essential.

□ Public private partnerships may be sought to close the gaps immediately in certain crucial services and supporting services– even as the system decides on building in house arrangements for the same. These include emergency obstetric services, ambulance services, blood bank services, advanced laboratory services, advanced imaging services and waste disposal services. The guiding principle for this is to first state the norms for the minimum level of services that would be guaranteed, then estimate what is available now and what part of the gap can be closed by filling vacancies and upgrading skills within a reasonable period and then closing the gaps for the remainder with partnerships. However, as a prelude to this the department would need to map the private sector and work out unit costs and regulatory and oversight mechanisms. For laundry and sanitation services there are no technical reasons for seeking partnerships, only an issue of where discipline can be maintained better and this may be decided in each district.

□ The post of programme officers should serve as assistants to the CHMO and be part of the administrative cadre. Instead of designating them in an ad-hoc manner each district may have four officers to assist the CMO who would hold largely administrative “deputy” CMO function. These could be a programme officer for RCH programmes including immunisation and family welfare, another for all other national programmes, a third for training and IEC functions who is in charge of the district training centre, and a fourth for purchases, distribution, logistics of all supplies and infrastructure. Along with the CHMO and with adequate administrative and office support, this would be a viable district leadership team. It needs to be emphasised that all the five should be trained in public health and ideally form part of an administrative cadre.

□ The Chief Medical Officer should necessarily be a regular appointment on promotion, with adequate training and experience working as both programme officer and a block medical officer and assured of a three-year tenure at

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The Chief Medical Officer should necessarily be a regular appointment on promotion, with adequate training and experience working as both programme officer and a block medical officer and assured of a three-year tenure at least. ... The post can be given powers the equivalent of the Joint Director. In most areas decisions must be taken at his level- only the exceptions, where the director's permission is needed should be indicated in the rules.

The district health society should be vitalised and should provide a forum for placing quarterly progress reports and for planning - and for the participation of civil society.

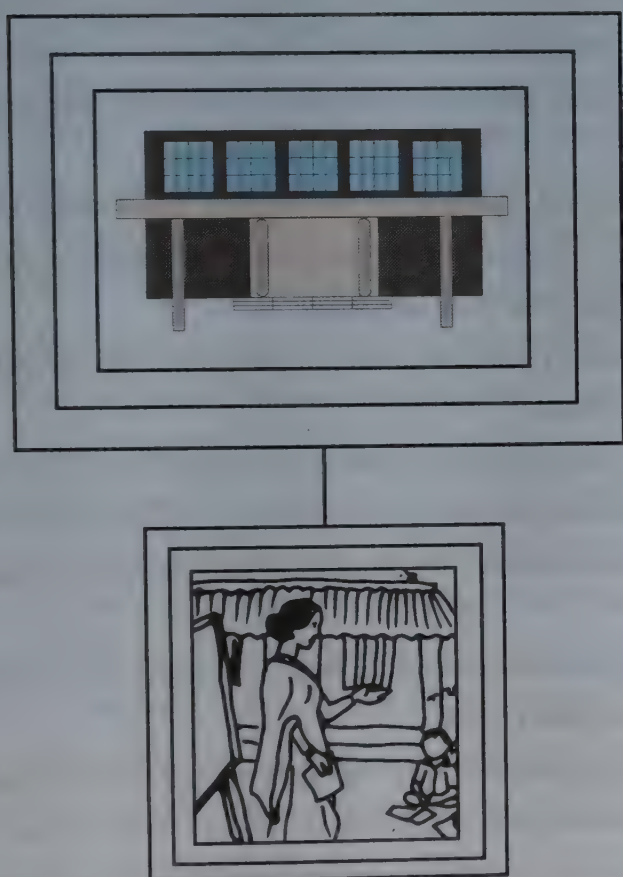
least. In such a context more powers can be delegated to this post. The post can be given powers the equivalent of the Joint Director. In most areas decisions must be taken at his level- only the exceptions should be indicated.

□ Till such time as there is an administrative cadre in place, the Chief Medical Officer when appointed for the first time may visit a district and be guided to understand the key "routine" administrative functions expected of him. A basic guidebook listing all his functions especially the administrative ones needs to be available to him.

□ The district health society should be vitalised and should provide a forum for placing quarterly progress reports and for planning and for the participation of civil society. The district panchayat head and the district collector should be given the role as chairperson and executive chairperson of this committee. They may approve the annual plan and budget for the district and then follow progress on the implementation every quarter.

Chapter - IX

Training Institutions and the Development of Human Resources



In this chapter we look at training needs, the current institutional strengths and mechanisms that cater to this training need and our recommendations to meet each training needs. We first discuss the needs, institutional strengths and mechanisms for in service training of the public health system, and make recommendations on these. We then briefly flag the situation in pre-service training for various levels of health care providers which leads to human resource availability for both public and private sector to recruit from.

IN SERVICE TRAINING

Training is a very important input in any process to improve the health status and quality of health services. All new programmes, and strategies require training of the staff.

Even existing programmes need retraining of staff to keep them updated. Besides training, the training infrastructure is also used for training community health workers, advocacy with stakeholders, and capability building of new players like Panchayati Raj institutions.

IN SERVICE TRAINING : SITUATIONAL ANALYSIS

In earlier chapters we looked at the training experience of various categories of staff. Summarising the cross cutting issues within the area of training, we note the following :

- ❑ In the last few years frequent training programmes have been conducted, largely based on funds made available under national programmes. Most of these consisted of short one or two day sensitisation programmes on different national programmes.
- ❑ Major recent training programmes which have had a longer, more than one week duration included training on Tuberculosis for medical officers, in malaria for re-skilling sector supervisors as microscopists and in RCH for multipurpose female workers. There has also been a major round of training of trainers at IIHMR, Jaipur for 92 senior officers. Another batch of 40 officers have had a management training programme in IIM Ahmedabad.
- ❑ However, no clear training plan with clearly defined goals exists as of now. As a result certain categories of staff receive little training and within categories some receive repeated training while many others may never attend any training programme over decades.
- ❑ There are very limited continuing medical education opportunities for medical officers and very little access to upgrading skills in areas of their choice.
- ❑ Supervisors have to provide technical support and on the job training to those whom they supervise. However, many of them are less exposed to any training programmes than those whom they supervise and do not even have pre-selection qualification in the area that would help them in playing this role.
- ❑ The medical officer's role as team leader, which includes providing technical supervision, and on the job training for the team, has not been appreciated at all.

The main problem with current in-service training programmes is its haphazard nature. It is haphazard in choice of trainees - some trainers having gone repeatedly and some not at all. Its choice of theme is dictated by the current vertical programmes and their priorities and the targets of expenditure they have set.

IN - SERVICE TRAINING NEEDS

Medical Staff

- ❑ Chhattisgarh has approximately 1700 class-II doctors and 900 class-I doctors in Government service.

- ❑ These doctors require at least two weeks induction training when they enter service – a completely unattended area. Such induction training is essential to explain the importance of national programmes, their own supervisory roles, the standard treatment guidelines and basic administrative and financial rules.
- ❑ Doctors require regular in-service training especially on national programmes, which their formal qualification does not equip them to handle.
- ❑ They need training to play administrative roles especially when they rise to become BMOs and programme officers.
- ❑ They need training to handle curative care roles without peer support and without much laboratory support.
- ❑ They need training to be able to train and supervise their paramedical staff on the job. Often as in laboratory services or family planning programmes –they themselves are not familiar with such work.
- ❑ Also given the lack of specialists, multi-skilling of both basic doctors and of specialists takes on urgency. One person with anaesthesia skills is required in every CHC. Therefore, the need for anaesthesia courses is well recognized. But the minimum set of curative skills that a CHC needs are: managing surgery for acute abdomen, doing a Cesarean section , blood transfusion and some rudimentary banking facility, neonatal care to handle pre-maturity, managing basic medical emergencies like snake bites(which require ventilatory support), diabetic ketoacidosis, emergency orthopaedics, a level of referral ophthalmic, ENT , dental and psychiatric care. We note that all these were part of the MBBS course and students have to pass the papers in most of these areas. Moreover, just a generation earlier MBBS doctors could and did manage this level. However, the norms have changed and the MBBS student who now graduates may have passed his paper in ophthalmology but would certainly flounder if faced with glaucoma case-even to provide basic diagnosis and initiate treatment. Specialisation leads to deskilling in areas outside the specialist domain. We, however, need to recognise that the deskilling is not only in the specialist but even in the general doctor. And that such deskilling has become a major impediment to quality peripheral health services. Imaginative solutions for this are needed.
- ❑ In addition to the above, we also need a special “cultural” orientation programme for doctors, especially those posted in remote areas. Such a course should cover ethnic diversity and focus on cultural gaps between health care providers and the patients so that the doctors can understand and relate to their work situation and develop empathy for those they serve. Current attitudes border on contempt and this is reinforced by differences of caste, ethnicity, wealth, education as well as vastly different life styles and value structures.

Paramedical staff

- ❑ There are about 8,000 multipurpose workers (including the staff nurse)–at the block, sector and sub-center level. They require regular training of at least about 15 days every year or as a first step

once every two years. This is for refreshing their knowledge and upgrading their skills and for multi-skilling them.

- ❑ There are about 1500 supervisors who need to be trained, to be retrained and multi-skilled to act as supervisors and fill in gaps in services.
- ❑ Training and multi-skilling of pharmacists and laboratory technicians is another major training load.
- ❑ Multi-skilling training of dressers, compounders and other minimally used staff of the system as well as uni-purpose leprosy workers who are now paid but not at all employed also need retraining and new skill acquisition.
- ❑ Recently the programme has laid stress on the integration of ISM practitioners for the public health goals. This group will also need training.

Community based Workers

- ❑ Another major focus of the health department would be to train trainers for the Mitadin Programme. The Mitadins themselves would be trained near their home villages, but to train 54,000 Mitadins for over a number of years requires about 2700 trainers and these would use the training infrastructure and training manpower available.
- ❑ Training of Dais is yet another major training load.
- ❑ There are more than 9000 village panchayats, and 270 urban local bodies. All of these require training as they have a major role to play in health care.
- ❑ Besides this there are large numbers of Anganwadi Workers to be trained on health issues.

Private Sector Involvement

- ❑ Training is also needed for doctors in the private sector especially in relation to public health programmes and diseases of public health importance.

Information, Education and Communication

- ❑ In addition to the above every category of staff above need to have a good understanding of the goals and methods of IEC so that it is integrated into every health programme at every level. Such an understanding requires an ability to assess current knowledge levels and behaviour patterns, to understand social and cultural contexts and to choose appropriate methods and strategies for effective IEC to take place. Since IEC is so training dependent and so cuts across categories of staff and programmes, we suggest that administratively it be closely related to training structures.

It is thus clear from the above that the State has an enormous training load. The State thus requires good training infrastructure and resource persons and a leadership plan to take care of this training load.

IN SERVICE TRAINING INFRASTRUCTURE

The existing training infrastructure in Chhattisgarh is not very good.

The State does not have a State Institute of Health and Family Welfare (SIHFW), and is still dependent on SIHFW Gwalior, Madhya Pradesh for its needs. A SIHFW is planned and construction is being initiated. Its construction in the best-case scenario would still take at least till January 2005.

The State Regional Health and Family Welfare Training Centre (RHFWTC) is located at Bilaspur. The state would require at three more such centres. Most of the current in-service happens in this centre.

Chhattisgarh has 16 districts. The State however has only 5 District Training Centers (DTCs). Given the training needs stated earlier it must move to have one DTC in each district, prioritising the building of new centers in such a way that we reach one per two districts within a year. We note that most of these new district headquarters are relatively undeveloped urban habitations. The availability of a meeting hall on hire is itself difficult. But training needs a good training environment which is seldom available. Moreover, since accommodation in hotels in such places is limited and of poor quality, one requires adequate residential facilities also. Given the remoteness of most working sites, intra-district trainees cannot be expected to return home every evening.

We would recommend, therefore, the adoption of two distinct in-service training strategies - one for paramedical and one for medical officers.

Recommendations for In Service Training

Even whilst the training institutions are being built up, a training task force headed by a director/ joint director needs to come up. Such a task force should plan and provide leadership and administrative support for a systematic training strategy.

- We would recommend, therefore, the adoption of two distinct in-service training strategies - one for paramedical and one for medical officers.

IN SERVICE TRAINING FOR PAREMEDICALS

- The training policy must specify that every two years, at least 15 days of training per MPW and health supervisor (male and female) must be attained. A roster of all MPWs and health supervisors should be maintained at the block and district level just for this purpose denoting the last trainings attended, and topics and number of days of training in each. The block medical officers may coordinate with district training centre to see that all their health workers have received the mandatory training.
- The training roster is preferably maintained by the head of the district training center, whose responsibility it becomes to ensure that all the MPWs and supervisors get the stipulated 15 days of training every two years and the syllabus for it should include-
 - ◆ Renewal of core area of their work e.g. RCH programme for MPWs.
 - ◆ Multiskilling training wherein as the first step female workers learn more about national programmes and about basic laboratory skills and male workers learn about RCH and adequate levels of basic laboratory skills.
 - ◆ Adequate training for first contact curative care based on the standard treatment guidelines.
 - ◆ Interpersonal and community mobilisational skills along with better understanding of cultural gaps in a multicultural and ethnically diverse society. This is particularly needed for persons working in tribal areas.
- In addition the department would require to organize training on changes in guidelines of national health

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programmes-best addressed through two day sensitisation programmes- whenever such a change is made.

- All training funds from various programmes are deployed in such a way that even as the objective of that grant is realised, the training goals the state has set for itself are also advanced within that same space.
- The supervisors should be held responsible for on the job training of the health workers. Periodic evaluation of knowledge and skills of health workers should be used to ensure that they perform this task adequately, as they should be accountable for this in their juniors. The medical officers must be equipped to evaluate the ability of supervisors to impart training in most areas. Additionally, in some areas like basic laboratory services and basic curative care they should be capable of providing the training on the job.
- Most other categories of paramedical - dressers, compounders, leprosy and malaria workers etc. also receive the same training package as MPWs as part of the approach to multiskilling.
- A training cell for in-service MPWs and supervisors training needs to be constituted in the SIHFW that constantly assesses training needs, training material development, master trainer training of district training centers, supervision of training rosters and training evaluation. This could be integrated with or have close linkage with the state IEC division.
- For training of sector supervisors female (LHV) and male (HA) three institutions need to be set up/designated. These three institutions may also serve for training of trainers for all community based workers and for IEC training and training on cultural aspects and above all for multi-skilling. The RIHFWTC at Bilaspur is one such institution.

We note that major steps have been taken in the correct direction:

- Two in-service manuals have been prepared for in-service training of Health workers.
- One of this is on strengthening curative care services

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A training cell for in-service MPWs and supervisors training needs to be constituted in the SIHFW, that constantly does training needs, assessment, training material development, master trainer training of district training centers, supervision of training rosters and training evaluation.

We recommend a Continuing Medical Education scheme for medical doctors to upgrade their knowledge and skills. This should replace the current practice of upgrading their knowledge through sporadic camps of national disease programmes.

provided by them through a standard treatment guidelines published in Hindi. The other is a manual on community involvement in major national health programmes and in RCH.

- ❑ An expanded essential drug list has been approved for MPWs.
- ❑ A plan has been drawn up to create a district training centre in every district.
- ❑ Training of trainers has been undertaken for each and every district.

What is needed is to make this policy and allot the necessary supervision and funds for this and to draw up a time bound plan so that the entire cadre receive at least 30 days training within the next two years. (to make up for the back log in lack of training).

IN-SERVICE TRAINING FOR MEDICAL OFFICERS

Continuing Medical Education

We recommend a Continuing Medical Education scheme for medical doctors to upgrade their knowledge and skills. This should replace the current practice of upgrading their knowledge through sporadic camps of national disease programmes. The envisaged CME scheme should also be useful for their promotions. A CME should be pursued as a very useful intervention strategy in health care delivery system.

We cannot possibly workout here the details of this CME and the policy that would govern promotions, but for the sake of illustration, we would like to indicate how it might work. The following features could be a part of such a scheme :

- ◆ Attending CME programmes organised by professional bodies.
- ◆ Completing a web-based feedback form or a professional periodical based feed back form that is filled in after studying the concerned section or sections a sort of questionnaire-but there is no pass and fail-only a proof of having read it.
- ◆ Completing study of CME package with in built

evaluation or a special CME publication. This could cover topics like the management of immunisation and the cold chain etc.

- ◆ Attending training workshops, training postings in special clinics (private or public sector) for acquiring skills like specific surgery or doing ultrasound etc.
- ◆ Completing a research project under guidance or a research publication.

It is possible to evolve a credit based CME¹ system which could be used for a promotion policy as well. About one third of total credit points needed annually would be from mandatory components and two-third would be chosen by the medical officer from a range of optional courses made available. The CME system would be based on non-threatening evaluation. Thus there is no one who fails - only a proof needed of their having gone through the course adequately and reached a certain competency - largely open book evaluations on previously announced questions that can be given whenever the person wants to. The system has also the ability to provide a lot of choice in such courses taken up. Acquisition of credit points from a wide variety of programmes on offer would be the key to acceptance of this programme by the medical officers.

Further we note that the government is committed to publishing a state drug formulary and a graded standard treatment protocol. Careful introduction and training on this material would be essential.

¹Such an elaborate continuing education process is what is required. Instead, reducing knowledge and skill acquisition and retention in doctors to some sporadic training camps on a few national programmes is unlikely to make for adequate improvements. For national health programmes like tuberculosis one needs to create a general knowledge - skill basis and a mindset - if the goals are to be met. Thus a training programme focussed on tuberculosis disease exclusively would not be able to give enough attention to its differential diagnosis. But if nine out of ten of those visiting with cough are not adequately treated merely because the cough is not tuberculosis then that medical

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Multiskilling is another challenging dimension of inservice medical officer training. But we need to plan this more vigorously so that in a five year time frame all 146 CHCs and district hospitals have an essential skill mix in each.

officer is unlikely to attract enough persons with cough or for that matter enough patients of any sort to the PHC. This common sense well appreciated in private practice is somehow undervalued in the public health facility.

Multiskilling

Multiskilling is another challenging dimension of inservice medical officer training. But we need to plan this more vigorously so that in a five year time frame all 146 CHCs and district hospitals have an essential skill mix in each. To do this therefore we need to

- ❑ Develop norms for what should be the skill mix needed at each level.
- ❑ Assess what are the institutions that are capable- anywhere in India of providing the sort of skill training we seek. These institutions may be public, private or not for profit institutions.
- ❑ Develop a basic course structure and quality standards for each of these courses.
- ❑ Get block teams to set themselves clear goals of what package of services they would like to achieve at each level and orient training inputs to meet this goal.
- ❑ The trainees should be posted to a medical college/ district hospital/private partner institution and attached to expert clinicians in their specialty for providing hands-on training. During the posting the trainees should be required to observe and practice pre-defined clinical skills and procedures. The trainees will be expected to repeat the procedures under observation of the expert clinician who will assess the levels of competence attained by the trainees. The clinical/technical training programmes, as identified by TNA, for each category of personnel, training venue, training duration, number of trainees to be trained, and number of batches to be organised have been identified and presented in following table.
- ❑ Develop supportive legal and administrative frameworks - indemnity insurance, transfer and promotion policy issues that can ensure that these skills would be available

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Develop supportive legal and administrative frameworks -for such multi skilling along with transfer and promotion policy issues that can ensure that these skills would be available to the system where it is needed after the training is over.

to the system where it is needed after the training is over.

- ❑ Provide for persons to periodically upgrade their skills within their chosen speciality as well.
- ❑ A sample of such skills that may be trained in a two year period is given below (adapted from the yr 2000 study). This list is an example not exhaustive.

Provide for persons to periodically upgrade their skills within their chosen speciality as well.

CHC - Skill Sets Needed & Approximate One year Training Load

Skill Category	Specific Skill Training Area/Subject	Duration (Days)	No. of Trainees Per Batch	Total Trainees	No. of Batches
Physician Skills	Management of ICU/ICCU	15	10	60	6
	Management of critically ill patients	15	5	60	6
	Medical emergencies package	15	10	60	6
	Endoscopy	10	5	60	6
	Training in USG and ECG	15	20	60	6
	Training in Echo Cardio.	15	10	60	6
	Essential Drugs and STGs	15	10	60	6
General Surgery Skills	Management of Trauma and Head injuries	15	10	90	9
	Laparoscopic surgery	15	15	90	6
	Basic Uro-Surgery	15	15	90	6
	Basic thoracic surgery	15	15	90	6
	Management of critically ill patients	15	10	90	9
	Orthopedic Emergencies	15	15	90	6
	Training in USG	15	20	90	5
	Training in Burn	15	15	90	6
Obstetricis & Gynecologiy	Laparoscopic sterilization	30	20	140	7
	Emergency Obstetric Care and Obstetrical Procedures for safe Delivery	30	10	60	6
	USG/HSG	15	20	40	7
	Caesarian Section	15	20	140	7
	High Risk Care During Pregnancy and Labour	(90)			
		15	20	140	7
	Safe Abortion/MTP	15	20	140	7
	Gynaecologic Problem and RTI	15	20	140	7

Pediatrics	Newborn Care and Neonatal				
	Emergency (Intensive Care)	15	5	50	10
	Care of Premature and LBW	15	10	50	5
	Management of diarrhoea and ARI	15	10	50	5
	Management of Severe Malnutrition	15	10	50	5
Anesthesiology	Training in Basic Anaesthesia for	15	10	50	8
	Surgical Specialists/MOs	(90)			
	Central Sterilisation and	15	10	80	8
	OT management				
Ophthalmology	Foreign body removal	7	10		
	Corneal ulcer, glaucoma, iridocyclitis	7	10		
Orthopedics	Management of polytrauma cases	15	10	20	2
	Practice in implant surgery	30	10	20	2
	Accident Emergency	15	10	20	2
Radiology	USG	15	20	20	1
	Special Radiological Investigations	15	20	20	1
	Management of Imaging Services	15	20	20	1
ENT	Bronchoscopy	15	5	20	4
	Removal of Foreign Bodies	15	5	20	4
	Blood bank management				
Pathology & Haematology	Basic laboratory management	7	20	140	7
		7	20	40	7

The above list illustrates the set of skills to be available in each district and some for each block. One may have, for example, a surgeon in a block who is trained in doing MTP as well or a gynaecologist who can manage basic urological packages and so on.

We note that any training strategy for achieving such ambitious multi-skilling as indicated above will necessarily involve-

- ◆ Rapid and adequate strengthening of the respective departments in state medical colleges
- ◆ Strengthening and accrediting a few district hospital to play this role.
- ◆ Extensive public-private partnership with private tertiary care institutions
- ◆ Standardization of course content and monitoring implementation and quality standards and evaluation norms.

Training strategy for administration, management and leadership

All programme officers, district officers and block medical officers need a formal induction in public health management, some aspects of hospital administration and epidemiology.

A three month course is advised either by distance education with some contact classes or by sponsoring to a training institution.

While block medical officers can take this course after appointment all other administrative posts for medical officers are open only to those who have served three years as block medical officers and they must take this course before being eligible for promotion.

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IN-SERVICE TRAINING INSTITUTIONS

Based upon the training load we need a considerable increase in training institutions. If an training institution is needed for over 300 days a year then it cannot be a hired premise - either it is rented or owned. We indicate below the training institutional capacity that we recommend:

If an training institution is needed for over 300 days a year then it cannot be a hired premise - either it is rented or owned.

S.No.	Name of Institution	Number existing	Number needed	Functions	Staff
1	District Training Center	5	16	About 1200 staff to be trained for two weeks each over two years: 30 bed accommodation and one batch at a time in small dts, twice this in other dts, thrice this in Ambikapur	One dt officer, plus three trainers-
2.	Regional Training Center	1	3	Six month training for male and female supervisors (120 per year) and in parallel focus on IEC, cultural aspects and multiskilling; (esp laboratory); training of trainers for community level workers	One head, plus six trainers
3	State Institute	0	1	Training of Trainers of all paramedicals; administrative training for medical officers and senior paramedicals, material development, research and policy planning, coordinating Continuing Medical Education Programme, Training Evaluation of all training programmes,	One director, plus twelve trainers

Medical College training Center	0	2	30 bed accomodation capacity focus on multiskilling medical officers and upgrading specialist officers; support to CME programme, teletraining
Private partnerships for Dai training.	0	30	Identify private sector conducting deliveries over 50 per month and reach agreement with them
Private partnerships for medical officer/specialist training	0	?	This relates to skill mixes for medical officers and specialists. Centers which can provide two to four week training on specific skills can be negotiated.

If the above pattern is agreed to then a number of existing facilities can be commandeered - and where none exist funds can be raised to fill the gaps. The under-utilised 100 bed hospitals may be able to help fill some of these gaps.

PRE- SERVICE TRAINING

We also need to look at the existing courses that generate fresh recruits for para-medicals, and medical professionals and suggest in what way they can be structured so as to fill the gaps identified. We would identify some key issues in this but would be unable to treat the topic comprehensively.

PRESERVICE TRAINING - PARAMEDICAL

The State has 5 ANM Training Centers (ANMTCs) and 3 MPW(M) Training centers. The latter are not functional. The annual intake of these institutions is 60, thirty per term. The institutions are:

	Place of Institution	Status	Status of facilities	Annual intake
Durg	Functional	Needs reequipping		60
	Kondagaon	Functional	Needs refurbishing	60
	Dhamtari	Functional	Building and equipment needed	60
	Raigarh	Functional	Building and equipment needed	60
	Rajnandgaon	Functional	Building and equipment needed	60
	Ambikapur	Functional	Building and equipment needed	60
	Total	6		300

The state has 4 General Nursing Training Centers at Durg, Raigarh, Bilaspur and Jahspur that give diplomas in nursing. It is planning to upgrade one of them into a graduate nursing training school. Other than this, there are a wide number of nursing schools in the private sector all giving diplomas in nursing.

It has currently no institution for training LHV's(the same as sector supervisor female) and HAs (the same as sector supervisor male).

The state has opened a community midwife-training programme directed to creating midwives in the private sector.

The state also runs nine paramedical courses.-Ophthalmic assistant, X-ray technician, laboratory technician, pharmacist, O. T. technician, etc.

One of these paramedical courses is only to train and certify "self declared private practitioners". There are six such courses today conducted in different district government hospitals .The quality and clinical basis of such teaching has been a matter of concern – to say the least. This course aims to train them on curative care for the private sector within a one year period. Standardisation of course content and clinical exposure is limited. Facilities and staff are generally inadequate. It thus has the danger of becoming certification without qualification. There is a considerable fee for this course. The first batch has yet to emerge. After that the quality of care and even where they choose to practice would become clearer.

The focus of these courses remains on producing quasi-doctors. The aim could easily have been

preparing (in 18 months) a number of multipurpose (multi-skilled) workers training institutions which would have high employability both in government and in private sector. The state also has a three year course on alternative medicine.

The state has enacted two legislations one for paramedical courses and one for alternative medicine course.

It is not clear where all the above courses are situated in relation to public health system needs. Almost all these courses are market driven and cater to a wide number of educated youth who see medical curative care as one of the most promising avenues of self-employment. Careful study needs to be urgently undertaken to test some of the important contentions about these courses:

- ◆ Do these graduates provide medical care in hitherto unreached rural areas or are they overcrowding urban areas and driving out good practice by more "populistic" practice?
- ◆ Are the graduates practising rational and ethical medicine, even comparing it to the already very low set base line of the standard MBBS private practice?
- ◆ Are their costs comparable and what does it mean in terms of economic burdens for the population?
- ◆ Do they have any paramedical skills what so ever which are currently useful?
- ◆ What elements of alternative medicine are utilised at the level of practice?
- ◆ Are the quality indicators and safeguards envisaged in the act followed in practice?

If the answer to most of the above questions is in the negative, we need to explore how many of these courses can be modified to provide the multi-skilled manpower that the system needs in contrast to this market driven approach. We suggest that even the private sector would find such multiskilled paramedicals more useful than these half way private practitioners who would only crowd the urban medical supply at the cost of quality and at great increase to the cost of care.

PRE SERVICE MEDICAL TRAINING

The state has one medical college at Raipur which is currently recognised and produces graduates and another at Bilaspur, constructed and almost crossed the recognition threshold, with classes ongoing, expected to produce the first batch in 2006.

Two more medical colleges at Dhamtari and Raigarh have been approved.

Also approved is a 300 crore centrally funded AIIMS at Raipur that may take up three to five years to become functional.

It would be too ambitious to try and encompass all of this within our analysis and recommendations. We merely note here that integration with state public health system needs to be as yet carried out.

Recommendations on Pre-service Training

PRE- SERVICE: MULTIPURPOSE WORKERS : FEMALE

If we expect the total requirement of the system to be 5000 MPWs (F) and 1000 LHVs we need not plan for more than a turn over of five percent per year given the fact that MPWs (F) would have on an average a thirty year period of service at least. This capacity would therefore be adequate to sustain the system, even if only half of those trained seek employment. At best we need to plan for more ANMTC. We, however, would have to build a non permanent system to take care of the back log for we do require about a 1000 to 1500 MPWs (F) immediately. However if we adopt the recommendation for two female MPWs per subcentre our pre-service need is for 8000 MPWs (F) and we need to look for an innovative expansion of ANM training.

One possibility is also to recruit from those with a diploma in nursing.

Another possibility is to identify 20 good higher secondary schools where pre service MPWF training can be offered as a vocational training course. This should have the capacity to generate a 1000 additional qualified people within two years. Care must be taken to ensure that teaching staffs are made available from existing trainers for MPW(F)s and senior public health nurses with strict stipulation that intake from ST and SC sections in proportion to the vacancy in these sections should be enforced. If the schools agree to pay remuneration to such staff and an orientation is organised for these additional teachers this training can be made of sufficient quality. Linkages with private sector hospitals and carefully selected CHCs can provide practical training also.

The schools chosen need not be government schools. Special preference can be given to private schools too which are currently functional and have a reputation for quality in tribal areas. This is needed because in many districts though there is no absolute shortage of candidates; there is a shortage only from

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One option is to revise some or all of the one year paramedical courses and the three year alternative medicine courses to generate multi-skilled male workers.

tribal sections. These courses should be located in those blocks where the gaps in para medical recruitment are largest.

After two years (two batches) such courses may become redundant or at least greatly reduced in requirement and this reduced requirement can be managed within the ANMTCs.

We may also consider directing the paramedical courses to provide multi-skilled workers with ANM skills too to fill this gap.

PRE SERVICE - MALE MULTIPURPOSE WORKERS TRAINING

There are two sanctioned courses in the state. Both are not functional.

One option is to revise some or all of the one year paramedical courses and the three year alternative medicine courses to generate multi-skilled male workers. The current paramedical training programmes and course on alternative medicine do not focus on public health and need to be redesigned. The minimum set of paramedical skills would be -

- ◆ Understanding of all public health national programmes and knowledge and skills needed to provide these services.
- ◆ Adequate ability to deliver RCH services where needed.
- ◆ A basic laboratory skills package.
- ◆ First contact curative care integrating allopathic and ayurvedic streams.
- ◆ As special optionals, radiography and ECG technician as well.

This syllabus change would be relevant only if there is a major policy change on multipurpose worker deployment as indicated in chapter-5.

PRE SERVICE- MEDICAL OFFICERS AND SPECIALISTS

- For producing more specialists locally it would be important therefore to upgrade the existing faculties of medicine, surgery, gynecology and pediatrics at the Raipur

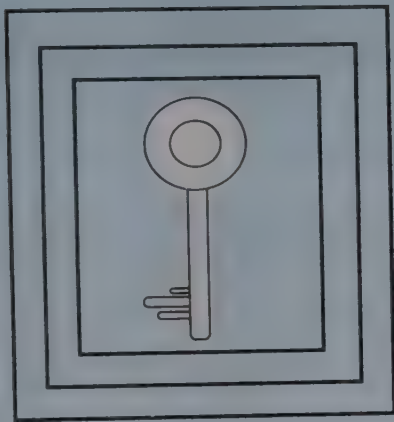
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medical college by moving to six units with about two postgraduates per unit per year - for the next five year period - by which time the AIIMS and other institutions would have picked up. Anaesthesia and ophthalmology which currently only produces two degrees and two diplomas per year may also double their intake. If in this we prioritise local doctors with five years of service using an interview plus written test to favour those likely to stay in service, we should be able to recruit easier and fill the gaps earlier.

- For more medical officers a number of medical colleges are opening up - and the political commitment is so strong on this front that any recommendation from us would be redundant.

Chapter - X

State Level Leadership And The Key Issues Of Workforce Management



In this chapter we look at some of the key issues of the organisation of work and workforce management at the highest level where it no longer remains an issue of administration but becomes an indicator of governance and we suggest changes that could make the state leadership of the health department respond to the challenges that it faces.

STRUCTURE AT THE STATE LEVEL

The leadership of the state level officers is undoubtedly one of the most important aspect of the public health system. The functions of the state are administrative, planning and supervisory. Under the administrative function the five most important roles are appointments including recruitments, promotions, transfers and purchases- of equipment and supplies and infra-structural development.

For these functions the state has a team (proposed) of four directors, four joint directors, nine deputy directors and nine assistant directors. The ministry guides this entire arrangement. The deputy directors are equivalent in rank to the chief medical officers but the joint directors rank above them.

The four directors have clear work allocations :

- ◆ The first director looks after medical education, which includes all the medical colleges and the paramedical courses. The director is selected from the teaching cadre.
- ◆ The second director looks after the indigenous systems of medicine and his work allocation is defined by this.
- ◆ The third is the food and drug controller.
- ◆ The fourth director – the director of health services is in charge of the entire public health system – all preventive and promotive aspects, and health facilities including district and tertiary hospitals. This represents the major part of the budget and activities. The director (health services) is also the secretary of the state health society. The state health society is the amalgam of all the erstwhile state disease control societies - AIDS control, malaria control, blindness control, and the Danida funded projects and the sector reform cell of the sector investment programme.

Below the director (health services) on the management pyramid are four joint directors. These joint directors(all officiating) have been allotted various programmes to monitor- one in charge of establishment, a second looking after tuberculosis and leprosy. another looking after blindness control and epidemics and a fourth looking after AIDS control and a special project. There is also a senior officer as a deputy secretary in the ministry and there is a joint secretary and a secretary of health and family welfare in the department.

In most areas, therefore, the director manages tasks by acting through a number of deputy directors. Currently there are five of them though there is provision for nine. (there is not sufficient clarity on exact numbers for reasons we shall discuss later.) One of them coordinates paramedical programmes another is assigned RCH another looks after purchases another after constructions and civil work another after malaria another after AIDS another after IEC and yet another after epidemic management. There is no officer coordinating a training plan at the state level.

All the chief medical officers of the district also report directly to the director.

APPOINTMENTS AND WORK ALLOCATION

The single most interesting observation that emerges in any study of the state level structures is that almost every single officer from the director through all the joint directors and the deputy directors and including all 16 chief medical officers and the block medical officers are only officiating i.e they are holding the office temporarily (in charge) and are not regular appointees to their posts. To fill them up definitively, promotions should have been carried out and this was a major expectation in many opting for the Chhattisgarh state cadre. But this has not happened. The bottleneck seems to be that there is a policy preference working in favour of ad hoc arrangements. Thus, there is no clear demarcation of what the various posts of director and joint director and deputy directors represent. The allocation of work between the joint directors and deputy director is at the discretion of the director. Even the exact number of such posts is difficult to ascertain. The loss is a lack of tenure with the resulting lack of accountability and a loss of long term planning. Decisions are of the moment and as there are so many programmes coming down from above, the chief medical officers are just able to respond to these.

As a result, no one has a long term plan or any clear plan for the portfolio they are holding except for what has been submitted as an annual plan where required to by a national programme. There is also no clear way in which postings are linked to performance or seniority. Most decisions on appointments to "holding office in charge" are subjective and there are no

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A work definition of the ANM and multipurpose worker exists - even if operationalising it is a problem. But for the leadership posts of joint director and deputy directors such a work definition is still to be created. The result of it is a huge concentration of powers and functions at the director of health services with all its attendant problems.

clear decision making guidelines in place. Noting that all of them come from the clinical side, their opportunity to master the administrative aspects, let alone the epidemiological and health management aspects is unlikely to be available. A work definition of the ANM and multipurpose worker exists - even if operationalising it is a problem. But for the leadership posts of joint director and deputy directors such a work definition is still to be created. The result of it is a huge concentration of powers and functions at the director of health services with all its attendant problems.

The appointment of the chief medical officers is also on an ad hoc basis. Neither seniority nor any due process or promotion or selection seems to be in place. Tenure is not assured. Changes of CMO are also therefore frequent and the problem again is that there is no long term planning in place. No qualifications have been laid down, or if they exist, have become largely paper instructions - for most officers are only officiating.

Powers to chief medical officers are limited and to block medical officers are non existent. A chief medical officer can make contractual appointments in multipurpose workers and in doctors. He can incur expenditure upto 2 lakhs rupees. He can ask a medical officer to officiate as block medical officers. Beyond this, in all aspects of expenditure, appointments, disciplinary action, he refers decisions to the state authorities. In health planning and initiatives, the national programmes largely bind him. Even for the post of civil surgeon the respective task allocations and responsibilities are ad hoc.

THE STATE HEALTH SOCIETY

The creation of a state health society by merging all the parallel health societies for tuberculosis, malaria, RCH, AIDS, and the CG Basic Health services programme was

- ◆ Hoped to improve functionality and coordination.
- ◆ Expected to provide space for expertise from the funding agencies, from civil society and professional associations
- ◆ Help in interdepartmental coordination.

It has been difficult to meet these expectations. For one, since the chief secretary is not on the committee, the interdepartmental co-ordination becomes difficult.

Functionality and coordination were the same as in the main department since in the state health society also, the minister chairs the governing body and executive committee. The health secretary is the vice president and the director, health service is the member- secretary. In effect no new energy or resource is brought in.

In the period of about 18 months of its creation, the executive committee has met twice - co-terminus with its governing body - and the decisions of even these two meetings have had little influence on subsequent actions.

It is seen only as a channel for funds from the central government, largely of funds given to the central government from external donors, bypassing the treasury. There is a need for evidence to substantiate the wish that the creation of such a society has made programme management more efficient. In the sense that a number of consultants are appointed by quick interviews, it has an advantage. But whether this has proven superior to a regular channel of appointment is to be seen. If this body has to serve any useful purpose it needs to be strengthened with a clear protocol of tasks and some separation of functions from the main department and by participation of civil society. A society that is completely governmental in actual functioning, with little role for non governmental sections, yet legally has a non governmental status is at best redundant and at worst a mechanism of decreasing financial and programmatic and legislative accountability. The case of Chhattisgarh's state health society, calls for reconsidering the whole strategy of para-statal registered societies, as a way of governmental functioning.

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RECRUITMENTS

The recruitments are to be done by the state public service commission for all senior posts- including medical officers, specialists, and for paramedical staff.

There have been no recruitments though the public service commission in the last four years. This has been possible since all the appointments made have been contractual and ad hoc. In the post of ANMs most recruitments is against posts that have no regular sanction. They are contractual posts under the centrally aided RCH programmes and are being filled up by contractual appointments. CMOs are authorised to fill up the posts.

In all other posts there are vacancies that should be filled up. There was some delay

At present transfers are sought after by repeated representations made by the person concerned and only some manage the ability to influence decision making in their favour. We have already noted how the lack of a transfer policy, and the lack of a transparent and non-discriminatory transfer decision mechanism acts as a major source of disaffection in the workforce and contributes to high vacancies in remote areas.

since the cadre division with the erstwhile parent state of Madhya Pradesh had to be completed. But though this has been largely achieved, the posts that remain vacant subsequent to this have not been filled up. There is a technical issue in this that all vacant posts at the time of the division of the state were considered abolished for the purpose of cadre division and they are to be created fresh in the post state formation stage. However, the latter has not been done. Thus the state has a number of employees in over 120 separate cadre but the number of posts that are needed by the norms and indeed the norms themselves have not been sanctioned by the new state. This too, therefore, is an ad hoc arrangement - after three years of statehood.

This lack of a sanctioned staffing pattern may be seen as an opportunity to rationalise and seek the desired pattern of staffing.

In the post of medical officers though there is a clear understanding of the number of vacancies at least at the PHC level, the selection process has remained contractual appointments. Not surprisingly, motivation and even the ability to train and deploy and retain such contractual staff, remains limited.

TRANSFERS

Transfers remain one of the main daily preoccupations of the directorate- drawing away considerable energy. At present transfers are sought after by repeated representations made by the person concerned and only some manage the ability to influence decision making in their favour. We have already noted how the lack of a transfer policy and the lack of a transparent and non-discriminatory transfer decision mechanism acts as a major source of disaffection in the workforce and contributes to high vacancies in remote areas. Understanding why, despite recognising its urgency, health systems have been unable to adopt such a transfer policy is the key to understanding the governance - administration interface.

PURCHASES

Drugs

Purchases of drugs are not through an open tendering process. Instead the rules allow for direct purchase from public sector units which in effect has become a route to avoid developing a cost effective system. The process followed is writing to a number of public sector units run by states, especially Karnataka, Maharashtra, Orissa etc. These units in turn pass on the order to their agents in Chhattisgarh. The agents secure the orders from the directorate and then in parallel they ascertain the requirements of the chief medical officers. They then supply the requirements to the chief medical officers. These orders are placed once or twice a year. Since public sector units do not produce such a large variety of drugs, there is some negotiation of needs, based on the supply side preferences. Thus we can find a number of drugs in a CHC which are in surplus as they have no use there (pancuronium or pentazocine for example where there are no surgical or intensive care facilities). Even then the way these public sector units manage to diversify products is noteworthy. Quality verification is weak and there is inadequate effort to meet the requirements of the essential drug list - nor even any move to alter the list to suit local preferences. On receipt of the drugs, payments are released from the directorate.

This system is effective in ensuring that some of the essential drugs are well stocked. It however fails to ensure adequate drugs of a wider list, nor is responsive to local needs. The latter is in part also due to the lack of an organised distribution system. It is also a wasteful system as so many costly, inessential and even hazardous drugs are still bought while cheaper essentials go wanting.

The figures on drugs purchased, costs, comparisons with open market costs are not in the public domain as in the Tamil Nadu system. There are no separate institutional arrangements for drug purchase and distribution. The directorate manages that too.

Equipment

Upto a sum of two lakhs equipment can be purchased directly at the district level. Above this the directorate purchases it. Again the requirements are often estimates made based on figures of number of centers of a particular category and they are poorly matched to facility by facility requirements. Thus we have centers with X-ray machines with no technicians and even some that were not installed over a few years. Or we have a number of neonatal advanced care units coming in where Caesarean sections have not been established and the number of births does not merit it. Or plenty of shadowless lamps and operation tables lying in

These mismatches between equipment and needs are of a very high order and certainly a waste on scarce resources. More so because in every centre visited or surveyed essential equipment from BP instruments to weighing machines at one end to ultrasound equipment and laprascopes on the other may not be available.

godowns of facilities where surgery has not been established.

These mismatches between equipment and needs are of a very high order and certainly a waste on scarce resources. More so because in every centre visited or surveyed essential equipment from BP instruments to weighing machines at one end to ultrasound equipment and laprascopes on the other may not be available. The need is to decentralise such decisions to district level and to make it based on a vigorous assessment of need and possibility of utilisation done at the block level:

OVERSIGHT/SUPERVISION

Since the regular directorate staff are managing so much of the above jobs like transfers, purchases etc on a daily basis and on a case by case, item by item basis, the cost of such allocation of work is borne by a decrease in the ability to organise supervision.

The senior directorate also perceive a lack of supportive staff like accountants, clerks, typists etc. as one of the main reasons for the problems since that means a greater work load on themselves. File movements are therefore very slow and little attention can be paid to the volumes of reports that come in.

One CMO interviewed had this to say "we send detailed reports. Then much later all of sudden there is a fax saying send a report immediately or else action would be taken. To locate and send the report in such short notice is very difficult and it is very demoralising for someone who has already sent the report." This view of file movement (read decision making) as having extraordinary bottlenecks also relates to the concentration at the top and the lack of sufficient delegation of work and powers at all levels. However, since all the national programmes need to submit progress reports – supervision becomes a mere chore of collecting and collating data at the junior level state staff. Regular field level supervision is not yet institutionalised.

The ministry takes some of these monitoring functions up but that could hardly be a substitute for the functioning of the directorate. There are once in two months review meetings at the state headquarters, which are useful but cannot substitute for a calendar of visits by state programme officers and the directorate to district for reviews.

PLANNING

Currently most planning is taking place at the level of the secretary. Recognising the problems both in skills and in manpower availability, the ministry has taken the initiative to set up a state health resource centre as an additional technical capacity of the directorate. The SHRC is not discussed here - it would require a separate independent evaluation.

Irrespective of the role of the SHRC, the planning capability of the directorate needs to be enhanced. Efforts in this have been begun with a two-week health management training for chief medical officers and senior state level officers. The mechanisms to formulate new and innovative programmes, to negotiate funds from donor agencies for necessary initiatives, to monitor and critically evaluate departmental programmes, to adapt centrally sponsored programmes to state specificities are all limited.

However, from a discussion with senior directorate personnel, the unanimous view that emerges is that they do not see this as a critical problem. Rather their perception is that without addressing the basic issues of tenure, work allocations, promotions, transfers and without lessening the role of much of the routine administrative work which ought to be delegated – it is unlikely that the directorate can come alive as a major center of planning.

LEADERSHIP AND THE ORGANISATIONAL CLIMATE

One of the key areas of study was to assess the organisational climate and leadership in the directorate and at the level of the CMOs and BMOs. This was done by Dr Vinod Arora using two instruments OCTAPACE and MAO-C and through detailed interviews. The detailed report is annexed (see annexure -1) but we give below the relevant summary.

“The respondents believe that overall, ‘dependency’ is the dominant motive that drives the organization while the ‘control’ motive is the back up one. On the whole, the department has clear cut channels of communication and is controlled by a few people who ultimately make all the decisions. The same is true of three organizational dimensions i.e, orientation, management of mistakes, and communication.

Two dimensions – interpersonal relationship and problem management are characterized by “dependency” (dominant) and followed by “affiliation”. This shows that the top managers control the organizations and depend upon their own in-group members, who are extremely loyal to these managers.

Another three organizational dimensions – supervision, conflict management, and trust – are characterized by “control” (dominant) and “expert influence” (backup). It means the depart-

ment is hierarchical but places more emphasis on good relations among employees than on the results. Informal groups based on relationship are relatively more important.

In the department, "dependency" (dominant) and "expert influence" (backup) characterize decision making and management of rewards.

Dependency is characterized by a desire for the assistance of others in developing oneself; a need to check with significant others (those who are more knowledgeable or have higher status, experts, close associates, etc.); a tendency to submit ideas or proposals for approval and an urge to maintain a relationship based on the other person's approval. Expert Influence motive is characterized by a concern for making an impact on others; a desire to make people do what one thinks is right; and an urge to change situations and develop people. Control is characterized by a concern for orderliness; a desire to be and stay informed; an urge to monitor events and to take corrective action when needed; and a need to display personal power.

This shows that the Department has a hierarchy. Most of the decisions are made at higher level in consultation with the experts. However, a few people, who ultimately make all the decisions, control the department.

On the risk taking dimension, the Department values maintenance of friendly relations among members, and shies away from using approaches which seem to be risky. Only a few persons (one or two) make most of the decisions. The climate in relation to innovations and change has "control" as a dominant motive backed by "expert influence". It again confirms strong bureaucracy in the Department where, though specialists' opinions are valued, rules are treated as being more important.

Out of twelve dimensions of organizational climate, seven are driven by the dependency motive predominantly. Except for influence, all the perceived motives, either dominant or backup, are dysfunctional for an organization and retard the achievement of results.

It clearly brings out that the efforts should be made to reduce the dysfunctional climates (dependency, control and affiliation) and increase the functional ones (achievement, expert influence and extension) for all the dimensions in the department."

Recommendations on State Level leadership issues

□ Core Administrative Issues

The central issues at the state level are issues of governance. They require political will – not merely administrative action. The minimum factors needed for an effective leadership for the department at the state level are a set of core administrative issues that depend on the role played by the ministry– tenure, promotions, work allocation amongst senior officers, transfers and purchases:

◆ Assurance of tenure

All posts must be for a period of three years. Any change in-between can be only on account of disciplinary action, on account of promotion or request to be relieved on account of illness or other personal grounds. The main posts that must be granted such tenure are the directors, joint directors and the chief medical officers and the block medical officers. Programme officers at state and district level and deputy directors will also as a rule have tenure but they may be shifted for administrative reason so that there is enough flexibility in the system.

◆ Promotion Policy and Vacancies

All vacancies must be filled up at the directorate (directors, joint directors, deputy directors, chief medical officers and programme officers at the state level) must be filled up within a period of six months on a regular basis from eligible staff at that level or by promotion, (except those posts that are to be recruited from the outside on a consultancy /contract basis where it could take upto a year). The posts of programme officers at the district level and block medical officers must be filled up within the same timeframe but in the event of creating a separate administrative cadre where these are entry points - they could take longer – upto a year.

The central issues at the state level are issues of governance. They require political will – not merely administrative action.

All posts must be for a period of three years. ... The main posts that must be granted such tenure are the directors, joint directors and the chief medical officers and the block medical officers.

All vacancies must be filled up within a period of six months on a regular basis from eligible staff at that level or by promotion,

This devolution of power for making purchases could be by creating a separate autonomous para-statal body to be headed by a non clinical management expert or even outsourced to a management firm to take charge of all purchases and distribution of drugs, consumables, equipment and infrastructural development (like the Tamil Nadu Medical Supplies Corporation in Tamilnadu

Yet another director who heads the role of capability development and planning and perhaps IEC would also head the state institute of health and family welfare and this, given the nature of the task, is best recruited on contract or on deputation from the open market with in house candidates also being eligible to apply.

◆ **Structuring the directorate and Work Allocation at the state level**

The four directors may have work allocations reordered so that the burden on the director of health services is reduced. This could be partly by passing some of the work to the other three directors. (For example the paramedical courses could be looked after the director medical education or the director of indigenous systems of medicine). One area of such devolution is purchases. This devolution could be by creating a separate autonomous para-statal body to be headed by a non clinical management expert or even outsourced to a management firm to take charge of all purchases and distribution of drugs, consumables, equipment and infrastructural development (like the Tamil Nadu Medical Supplies Corporation in Tamilnadu which is headed by an IAS officer). This would free the director of health services to attend to the core administrative issues, increase oversight of programmes and take an active role in planning. Or it could have an independent director in charge of purchases backed by a cell. Yet another director who heads the role of capability development and planning and perhaps IEC would also head the state institute of health and family welfare and this, given the nature of the task, is best recruited on contract or on deputation from the open market with in house candidates also being eligible to apply. Even after such devolution the director of health services would have a very large but potentially manageable portfolio. The present portfolio where all of this is with the same person is obviously at a cost to the efficiency of the system. We feel that this mix of four promotees and two recruits (on contractual/deputation basis) from the open market and the mix of skills proposed would give the much needed dynamism that a vibrant public health system needs. In addition to this or as part of this (integrated with or in conjunction with the SIHFW) a formal state civil society partnership institutions like the SHRC would continue to have relevance.

The joint directors would be also given a clear charter of work where one assists in charge of core administrative issues, while the others assist the director in the supervision/oversight of

all the programmes. Six deputy directors would be the programme officers at the state level as well as three who assist in core administrative issues of the three other directors.

◆ **Transfer Policy**

The Health department shall have an effective fair transfer policy. The details of this would have to be worked out but the key principles on which this would be based are:

- Transfers at the state level and between districts would be done by a transfer tribunal which would consider all cases before it once every two months. Considering the political importance of transfers it would be probably required for the tribunal to be headed by the minister himself (as it is in Madhya Pradesh where a similar tribunal is in function)
- Transfers within a district would be done by a similar panel. Certain category of staff would be district specific in recruitment and would normally be eligible only for transfer within the district. Exceptions to this rule- like shifting to the place of work of a spouse- would be laid down and they would apply to the state transfer tribunal.
- All districts and within districts all sectors would be classified as difficult, moderate and easy. Those who have served in difficult and remote areas for five years shall have a first priority in transfer to a less difficult area- within districts and between districts.
- Similarly all cadre would be expected to serve at least for five years in a difficult area. For those entering service it would be ten years, which could be done in 2 or 3 stretches. Those who have already crossed 45/50 years of age would be exempt from this rule. Difficult area postings would attract a "difficult area allowance." Moderately difficult areas would also have an allowance though for transfers they would not be differentiated from easy areas.
- All promotions would be accompanied by a mandatory transfer for those who opt for administrative cadre.

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The essential drug list and the norms for health services provision adopted by the state should inform the policy on purchases and infrastructure development.

◆ **System of purchases and infrastructure development**

The essential drug list and the norms for health services provision adopted by the state should inform the policy on purchases and infrastructure development. These would define the minimum drugs, the minimum set of equipment and the minimum infrastructure development needed for that level of care. Such a state level system is not incompatible with decentralisation. On the other hand, it is almost a precondition for it. The human power and expertise needed to select and finalise purchases of a bewildering range of drugs and equipment would just not be available in all districts and cannot be built up without costly redundancies. But the current centralised system is inefficient with high degree of mismatches and bottlenecks and suboptimal in the use of scarce financial resources.

The state's role is to provide for a separate office if not an institution headed by a management person with experience in procurement and supplies. Delegating a clinician to this is inappropriate, though close coordination with clinicians would be essential. Such an office can complete pre-qualification of companies, issue tender documents and negotiate prices and place orders on behalf of chief medical officers for all supplies - drugs, consumable and equipment. Such collective bargaining can give better prices than if each district head bargained on his own - but the requirement would be that of the district. The further advantage is that by monitoring stock positions on a daily basis, and linked with a distribution system, the supplies of drugs can be flexible and streamlined to meet the needs of the system. The key recommendation in this is outsourcing to a management firm or a para-statal body created for this purpose headed by a management person taken on contract. This firm has to display its final rates it has secured and show comparisons with other states and public sector units to show that it has been able to get quality at rates comparable to the best deals in the nation. Quality

The state's role is to provide for a separate office if not an institution headed by a management person with experience in procurement and supplies. Delegating a clinician to this is inappropriate, though close coordination with clinicians would be essential.

testing of drugs and Maintenance of equipment, both of which have very poor or non-existent arrangement, would be taken care of by this. It should further display the entire process on a website so that it is part of the public domain. In infrastructure development, again, it would provide assistance to the CMO in design specifications, tendering and issuing contracts. Requirement would be specified by CMO and even payments could be made from the CMOs office under such decentralisation.

This is not a new idea. Broadly this is what the Tamil Nadu Medical Supplies Corporation has achieved and it provides consultancy for this. One may go further and seek with TNMSC or a private management firm a BOT (Build Operate Transfer) agreement, including into this agreement indicators not only for building the system but also a planned capability building in the department and eventually transfer of this to a state body.

Autonomous Supplies Management Agency in Tamil Nadu, India.

The Tamilnadu Medical Services Corporation (TNMSC) was created in 1995 to contain drug costs and reduce shortages by purchasing and supplying drugs to government health care facilities. TNMSC is set up as a government company, with a Board chaired by the Secretary of Health, which is accountable to the Minister of Health. The TNMSC created a list of 267 essential drugs from the previous state drug list of 900 items.

Drugs are procured through tender and delivered directly to district level stores. Quality assurance procedures are in place, including sampling of products from manufacturers and district stores. Testing is contracted to reputable private laboratories through tenders. TNMSC adds a 5% charge to fund its own operations. Each facility is given a budget target and issued a pass book in which to record the value of drugs it has received. Till its annual budget is exhausted each facility can place its indent directly with the district warehouse and have it replenished within a week. When stocks of our drug fall below two months reserve in any district warehouse a fresh order to supply that district is placed within that week.

Decentralisation is essentially a political process with district and local level governance being the key.

Our recommendation is, therefore, to make delegation of powers to districts conditional on the following five features (flowing from the recommendations above) being in place. :

- ◆ *The chief medical officer must be a regular appointee-not officiating.*
- ◆ *The chief medical officer must have a minimum tenure of three years.*
- ◆ *The chief medical officer must have served as block medical officer or programme officer (be part of the health management cadre if this is created)and officer must have had public health management training (for ensuring capability)*
- ◆ *Purchases and infrastructure development must have the state level managerial support arrangements as indicated above.*
- ◆ *A state level body for capability building and technical advise on planning must be accessible to him/her.*

□ DELEGATION OF POWERS TO DISTRICTS (As Distinct from Decentrization)

Decentralisation is essentially a political process with district and local level governance being the key. This is discussed in some details in the last chapter. Here we are looking largely at devolution and delegation of planning and administrative functions to lower levels.

Such delegation and even decentralisation is necessary if we are to have a health plan that is flexible and responds to local needs. It is needed as a better system of administration. It allows for creativity and innovation. It allows for different rates of growth responsive to human resources and the quality of leadership provided.

However, we need to view decentralisation in the current context – where there is little innovation, where there are serious mismatches, where officers are officiating and accountability is non enforceable, where management skills are low and where administrative powers and financial resources are limited.

Our recommendation is, therefore, to make delegation conditional on the following five features (flowing from the recommendations above) being in place.

- ◆ The chief medical officer must be a regular appointee-not officiating.
- ◆ The chief medical officer must have a minimum tenure of three years.
- ◆ The chief medical officer must have served as block medical officer or programme officer(be part of the health management cadre if this is created)and officer must have had public health management training(for ensuring capability)
- ◆ Purchases and infrastructure development must have the state level managerial arrangements as indicated above.
- ◆ A state level body for capability building and technical advise on planning must be accessible to him/her.

If all the above conditions are satisfied, then the chief medical officer's powers can be enhanced to a level where it includes modifying and creating his own health programmes based on the district health plan and seeking budgetary support for it. All purchases required to reach recommended norms of service delivery, drug supply as per the list, district level recruitment, promotions and training to reach service delivery norms should be incrementally brought under the district powers.

In the absence of these five criteria being realised the existing powers are perhaps what is optimal – along with rigorous supervision.

□ THE DEVELOPMENT OF A HEALTH ADMINISTRATIVE CADRE

This needs to be considered in detail by a broad based committee. The broad concerns are as follows : For clinicians, administrative tasks, however complex, are often seen as akin to chores requiring common sense not trained skills. It is often even regretted as time taken away from clinical work - especially patient care. We must first concede this desire to remain clinicians as a legitimate point of view. However since promotions and status inside the system are related to administrative roles few clinicians can pass this up however dedicated they are to clinical work- especially as they would then have to take orders from their juniors!!

On the other hand, administration is not common sense and public health management as different from administration is a challenging domain which requires specialised training. There are some who like doing so and for many reasons would prefer this for their career. But to give up clinical work especially in the private practice domain is not only a loss of status, it is a loss of income also. These contradictions need to be resolved pragmatically by charting a career plan for the two types such that the dilemma is resolved and the public health system benefits from what clinicians are good at and interested in rather than become another manifestation of Parkinson's law.

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On the other hand, administration is not common sense and public health management as different from administration is a challenging domain which requires specialised training.

The general principle is that for the first ten years everyone is of a common cadre and then they choose one of two career plans - both with their own attractions.

The suggestion is that a health administrative cadre be created of all the persons working as BMOs, CMOs, district and state programme officers, officers in the training institutions. These persons are paid 25% or such of salary as non practising allowance and forbidden from practice. They are further given a travel allowance for supervision work if not provided with a vehicle. Their opportunities of promotion are easier but they would have more transfers and would have to serve in difficult areas first. They would get one year's training over two or three spells - in management, in public health and epidemiology and health planning. They could be eligible for a one year sabbatical once in six years.

Those who do not opt for this get no allowance and face less transfers. They have little promotion avenues though specialised training can enhance their clinical skills. They can however rise to head district and sub-district civil hospitals as civil surgeons and with hospital administration training go onto being medical superintendents of tertiary care hospitals.

The details have to be worked out. The general principle is that for the first ten years everyone is of a common cadre and then when they become class 1 officers they choose one of two career plans - both with their own attractions.

There must be a future to look forward to for doctors who commit themselves - if the morale of the workforce is to rise. To talk of doctors not being sincere when they are so demoralised and frustrated is a failure of administrative and political understanding. True, there are some doctors who come from an elite background, who are unable to adjust to the rural environment. But there are also many, many doctors we met who are tribals or from modest homes, often first generation learners, to whom becoming a doctor was and still is an achievement. Their demoralisation must be seen as an administrative and political failure.

There must be a future to look forward to for doctors who commit themselves - if the morale of the workforce is to rise. To talk of doctors not being sincere when they are so demoralised and frustrated is a failure of administrative and political understanding.

□ **DEVELOPMENT OF MANAGEMENT SKILLS & THE DEVELOPMENT OF PLANNING CAPABILITY**

Development of capability requires training inputs. This is well understood and as we introduce mandatory training for all district programme officers and chief medical officers and deputy directors we would get such staff in the directorate. A three month health management course by a national institute done by correspondence would be the basic minimum qualification needed.

It is also important to ensure that all those who become joint directors or directors have served as district chief medical officers and that all deputy directors and CMOs have worked as BMOs or district programme officers.

Development of planning capability in the directorate requires further inputs from operational research and from epidemiological work. Understanding the rigour of this by participating in this or at least using such reports consciously needs to be built in. Without it planning is arbitrary, unscientific and becomes an expression of power relationships with dependence on externally made and poorly adapted programme designs.

Further, in the current context, planned interaction with the NGO sector active in health advocacy or community action at both national and state level is essential for the state health leadership to develop a critical insight into one's own mindset. Continued interaction with body representing state- civil society partnership like the SHRC must there for be welcomed and provided for.

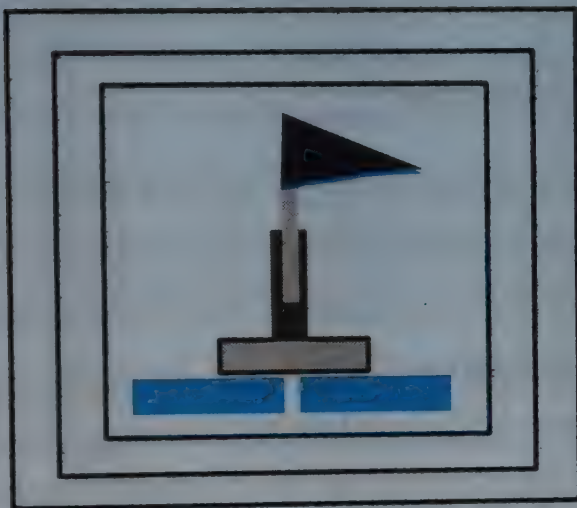
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Chapter - XI

A Systemic Overview and Strategies of Implementation



This final chapter makes an overarching summary of all the recommendations made for each level of the multi-tiered health system - the subcentre, sector, block, district and state level. It then goes on to recommend three broad strategies of implementation - one at the operational level, the second as a set of administrative measures and a third at the level of the legislative.

And yes, please do read the conclusion ...

An Overview

We have seen in chapters 4 to 6 the large gaps that exist in access and the even greater problems of functionality. We note that in a state with such a large remaining problem of poverty the public health system remains the mainstay of any sort of health care for the poor. Also the burden of disease, largely preventable, adds to their poverty by robbing them of working days and their capacity to work and by draining their income into largely irrational curative care. The need to strengthen the public health system is evident. At the level of health administration, there are a number of components to attend to.

These are

- ☐ workforce management
- ☐ rationalisation of services
- ☐ human resource development
- ☐ decentralisation of health services
- ☐ the design of health programmes
- ☐ financing of health care issues
- ☐ private health sector integration in public health goals.

This study has focussed its attention on the first four issues. It has not addressed the design of health programmes. Thus issues like what is the best way to ensure institutional deliveries, or control malaria, or provide health care for the urban poor have not been addressed. We are particularly concerned about our inability to address the issue of the urban poor, a problem which is growing rapidly and where even a basic approach has not yet been articulated. We have not even touched upon the financing of health care. We had initially considered mapping the private sector and looking at its potential but soon had to conclude that it required a separate study as the logistics and effort needed were such that it could not be included into this. All these would require follow up studies - each as complex as this.

Our main recommendations therefore pertain only to strengthening (including where necessary expansion) of public health services by better workforce management, human resource development, rationalisation of resources and systems including where appropriate public private partnerships, and the delegation of powers and decentralisation to the districts.

We summarise below the crosscutting issues across different levels on which we have made recommendations before we go on to suggestions for implementing them.

The key recommendations in workforce management are that we have made relate to-

- ◆ A transparent and fair process of recruitment mainly into the regular workforce through the public service commission. Contractual appointments may be considered supplementary and not become the main form of recruitment.
- ◆ An effective and fair transfer policy – effected by a representative duly appointed board.
- ◆ A promotion policy that is fair, prompt and that offers motivation to all categories of staff.
- ◆ The creation of a medical administrative cadre and along with it a promotion policy and cadre restructuring such that it leads to an acceptable if not attractive, career plan for the medical professional.
- ◆ Security of tenure for all administrative posts along with clear definition of responsibilities and powers at each level.
- ◆ Re-defining the job responsibilities of all staff at the PHC and HSC level as indicated with greater emphasis on the feasibility of achieving these tasks and the use of multi-skilling at all levels to reduce redundancies and improve distribution of tasks amongst the entire staff. Redefining these facility staffing patterns based on the revised job norms.
- ◆ Reducing area of coverage by having two MPW females per subcentre.
- ◆ Defining a policy for remote medically underserved areas where greater reliance is based on paramedicals, and doctors are called upon to make periodic visits from the nearest CHC strengthened to meet this demand.

As regards the rationalisation of services, our key recommendations relate to-

- ◆ Adopting norms for service package delivery at each level. The sub-centre level, the PHC level, the CHC level and the district hospital level along with a road map of how to move from where we currently are to what is decided by policy as the minimum desirable. This has been done for Chhattisgarh and is given in annexure-2.
- ◆ Developing a road map for each block which locates the current situation in service delivery as compared to the norms adopted above. It builds a road map to closing the gap.
- ◆ Optimising location and distribution of services helped by a GIS based software and closing gaps in physical access by ensuring that all sectors have functional PHCs and all blocks have CHCs.
- ◆ Rationalising the purchase of drugs, consumables and equipment by developing a separate system of purchases as indicated and thus being able to match equipment and drugs to availability of trained manpower and infrastructure and arrange for maintenance and responsiveness of the system to variations in needs.

- ◆ Bringing in the Indian systems of medicine into the block and district level plan.
- ◆ Using public private partnerships to achieve close service delivery gaps immediately even as more long term efforts to strengthen human-power and infrastructure continue.
- ◆ Integration with Mitadin programme.

As regards Human Resource Development the key recommendations are :

- ◆ A separate institutional mechanism for planning and guiding capability development-linked to the state institute of health and family welfare development.
- ◆ A plan for in-service training with a minimum number of training days for each category of staff and a clear delineation of the skill set needed for each staff towards which in-service training builds them up.
- ◆ A continuing medical education programme for medical officers.
- ◆ Multiskilling of doctors to provide an optimum set of skills and the CHC level.
- ◆ Mandatory Management Training- a three month programme - if needed by distance education with adequate contacts- at the point of entry into administrative positions and further training in public health and epidemiology if they are to move on to senior planning positions.
- ◆ On the job supervision and support providing adequate skills and quality in the staff – such arrangements to be organised through adequately trained supervisory staff led by the medical officers.
- ◆ A follow-up study on the course content of paramedical courses and alternative medical courses so that it fulfils better the needs of the state health systems in the light of adoption of the key recommendations of this report.

As regards delegation of powers to districts and blocks

- ◆ the key recommendation is that such delegation of power should take place only in the context of adoption of the basic recommendations of tenure, promotions and transfer and support systems on purchase and planning. If these conditionalities are achieved, then decentralisation of administrative and financial power can provide a public health system comparable with the best in the world and probably more cost effective as well. If, however, they are not met, decentralisation by itself would reduce accountability and decrease state government responsibility.
- ◆ Delegation should also be linked to the development and monitoring of block and district level plans.

- ◆ Delegation & decentralisation should be preceded by and supported with an adequate programme of public health management skill development.
- ◆ Delegation of powers and decentralisation of planning should be seen as a step towards a more comprehensive decentralisation of political powers and resources to Panchayati raj institution.

THE ROLE OF PANCHAYATI RAJ INSTITUTIONS (PRI)

Increasing the role of PRI in the governance of the health sector flows out of a constitutional commitment. This would require a transfer of the major part of the funds and the administrative control to the panchayats - placing different facilities in the control of different levels of the panchayati raj institutions. The mechanisms of such a change in governance- the rules and regulations and the technical support and systems needed form part of a separate study by a task force, given such a political mandate. This study sets itself only a limited mandate of incremental enhancement of PRI role and capabilities- so that it can anticipate and facilitate a large political initiative towards political decentralisation.

A situational analysis reveals only three roles with PRIs as of today. One is in the implementation of maternity benefit schemes; the other is in the implementation of the referral programme and the third is the requirement that an ANM gets a signature from the panchayat sarpanch every month before she collects her pay. Experience in these three limited roles has not been positive. Many panchayats have not been able to spend the sums allotted. The problems include snags in cash flow to the panchayats and the lack of clear guidelines in how to use these funds and the lack of referral centers to which they can be referred as well as other design problems in these schemes. The system of signature is complicated by ANMs turf often extending to more than one panchayat and by either undue generosity or undue harassment along with a lack of redressal mechanisms for the ANM. There is something questionable in the spirit in which transfer of powers to panchayats has been reduced to transferring part control over only the most vulnerable and presently effective person in the system— without any other parallel move to either enhance panchayats role or facilitate these services. In effect it has only added one more task to her long list without much advantage to health care.

Discussions on the role of panchayats evoke major differences amongst various stakeholders - the only area in our recommendations where there were sharply divergent perspectives expressed.

The concerns of employees and the medical officers and the state leadership were largely related to being accountable to a system whose own capabilities and accountability was so limited. There was also considerable questioning of whether the PRIs as they were today were truly representative of the weaker sections of society or whether they were merely representatives of rural elite groups.

On the other hand, it was argued that transfer of power to panchayats was not only a constitutional and democratic necessity, but also the only way of ensuring accountability of a recalcitrant system. It was also one effective way of addressing all the problems of governance that the system currently faces. In such a perspective, the current problems of governance relate to concentration of power at the top.

Yet another concern was that in the current context, a move to transfer health sector to panchayats would transfer responsibilities without transferring powers and much less finances - even if these are envisaged at the time of policy articulation. Though issues like quality of care could be written into any such policy, in the process of implementation they too would get filtered out by different pressures, foremost amongst them being the pressures for the state to retreat from building up public sector commitments. Such has been the experience to date. In such a context, we see merit in a more gradual transition where along with increased powers, capabilities are built up, core issues of administration highlighted earlier are addressed and an adequate support system at the state level is in place. Such a system should be able to identify uneven growth, provide technical support and ensure that the quality of care is safeguarded.

The Janpad panchayat head, and three representatives from the other panchayat structures may form part of a block health coordination committee (BHCC) with the BMO, assisted by three health department employees. The BHCC should also have two or three representatives of civil society active in the area of health or human rights.

Recommendations on Enhancing Panchayati Role

- The Janpad panchayat head, and three representatives from the other panchayat structures may form part of a block health coordination committee (BHCC) with the BMO, assisted by three health department employees. The BHCC should also have two or three representatives of civil society active in the area of health or human rights. Such a committee shall-
 - ◆ Be part of drawing up a block level health plan and its implementation.
 - ◆ Oversee the regular functioning of the CHC and the PHCs and through the RKS mechanism raise funds for them to fill in critical gaps.
 - ◆ Play a leadership and facilitator role in the Mitani programme
 - ◆ Assist in all disease control programmes esp. vector control and control of gastrointestinal disease, tuberculosis and leprosy.
 - ◆ Assist in the control of epidemics implementing a panchayat disease outbreak protocol when alerted.

This committees' functioning shall be enabled by a fund- and not from the RKS fund- and may have administrative staff as needed to manage that fund effectively. This fund shall be towards a charter of work to which it has an understanding that it would perform.

The block level planning effort and the building of an effective block level coordination committee should be first taken up in the EQUIP blocks and then expanded to cover all the blocks. When these are well in place, the shift to more effective district health societies, as part of political decentralisation would be more achievable.

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The district health society can take on all administrative roles when there is sufficient confidence and political will for such decentralisation and the entire budget shifts to its control. Even then it would need strong technical support in purchases, administration and training and maintenance of standards from the state.

Towards such a goal the current recommendations would form interim steps.

□ The district panchayat's chairperson may be the co-chairperson along with the district collector of the district health society. His approval of the annual budget and quarterly reports would be mandatory- though he would not as yet have day to day control over financial operations. The district health society should have in addition some more members elected from the GP level, the Janpad level and the municipalities. It should also have two or three civil society members who can play an effective advocacy role.

The district health society can take on all administrative roles when there is sufficient confidence and political will for such decentralisation and the entire budget shifts to its control. Even then it would need strong technical support in purchases, administration and training and maintenance of standards from the state. Towards such a goal the current recommendations would form interim steps.

STRATEGIES FOR IMPLEMENTATION

Much of the recommendations made are well known. They have however not been implemented because they are linked to issues of governance and larger systemic changes. They need political action. Some of the recommendations require only administrative action, permitted by political support. This is easier to secure. However, the effectiveness of such suggestions in the absence of the core workforce management issues would be limited. And finally, there are sets of issues that require mere administrative action, issues related to skill development for instance, but whose impact would be limited without corresponding core issues changes.

How do we then proceed? This study group does not see itself as making a set of non-implementable recommendations but would like to go further and propose three key parallel strategies of implementation.

One strategy would be to move towards legislative action to make for a political reform. The second is to move for administrative changes building consensus amongst stakeholders. And the third is focussing on the soft areas of leadership and morale, or programme design and local planning linked with adequate provisioning for minimum package of services and taking up block after block to demonstrate the possibility of change even within the existing system, while sustaining the dialogue on more substantial policy changes.

This study group does not see itself as making a set of non-implementable recommendations but would like to go further and propose three key parallel strategies of implementation.

One strategy of implementation would be to move towards legislative action – to make for a political reform. The second is to move for administrative changes building consensus amongst stakeholders. And the third is focussing on the soft areas of leadership and morale, or programme design and local planning ... and taking up block after block to demonstrate the possibility of change even within the existing system.

Better infrastructure, better manpower situation and better provisioning of centers with supplies do not add upto better quality of care. Failure in ensuring quality of care is one reason why both public and internal demand for improved public health systems has become muted.

STRATEGY - I

BASIC LEVEL OF OPERATIONALISATION BUILDING AROUND QUALITY-BLOCK BY BLOCK

THE EQUIP (ENHANCING QUALITY IN PRIMARY HEALTH CARE) APPROACH

- The most important and recurring dimension of the study report is the problem of quality of care and the current inadequacy of the systems' perception of the problem. Thus sector PHCs' report drug situation as satisfactory when half the essential drug list is unavailable there; the importance of the laboratory to the practice of medicine is almost forgotten; sanitation inadequacy is not perceived, beds are not covered with linen and so on. Better infrastructure, better manpower situation and better provisioning of centers with supplies do not add upto better quality of care. Failure in ensuring the latter is one reason why both public and internal demand for improved public health systems has become muted. The mix of organisational, motivational and leadership factors that have to be addressed are "soft" issues from the viewpoint of administration and require a different approach than mere administrative diktat.
- Many recommendations need increased motivation, planning and planned provision of resource inputs to close gaps in supplies, equipment and infrastructure. Attempts to close such gaps across the whole state as one effort, driven by a big purchase or a single order, has led to lot of mismatches and redundancies in the past. Inability to provide adequate state level

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supervision and skill development to match such hardware improvements has worsened the mismatch and the redundancy situation. We, therefore, suggest that a Quality driven approach be initiated in a set of blocks , then potentially expanded to more blocks in phases till the whole state is covered. These block level plans should make full use of this study and its recommendations and try to address many of the concerns in the following steps.

- ◆ In a given block a planning resource group helps the block draw up its health priorities by beginning with a situational analysis, which would include assessing quality levels against a set of standard reference norms.
- ◆ Goal setting at the block level is then undertaken for each national programme and for local health priorities. Goals are set in a participatory manner, not only on numerical targets, but also on quality of care. The focus is on building a team approach under the BMOs leadership to achieving goals set by themselves in a facilitatory environment.
- ◆ Planning optimal location of sub-centers and PHCs and organising relocation especially where there are no buildings or buildings are not in use. A GIS based database of current distribution should be made available to facilitate this.
- ◆ Skill development in existing staff in these blocks so as to provide minimum skill -sets needed at each facility
- ◆ Identifying manpower gaps in these blocks and closing them-both by recruitment and transfers on

We, therefore, suggest that a Quality driven approach be initiated in a set of blocks , then potentially expanded to more blocks in phases till the whole state is covered. These block level plans should make full use of this study and its recommendations and try to address many of the concerns in the following steps.

Goals are to be set in a participatory manner, not only on numerical targets, but also on quality of care. The focus is on building a team approach under the BMOs leadership to achieving goals set by themselves in a facilitatory environment.

Since this programme is about closing gaps through matched resource and skill inputs, a good name for this - an effort already being initiated - is EQUIP - Enhancing Quality In Primary Health Care Services.

- a priority basis while ensuring that all existing staff members have a seven hour working day through job redefinition and reskilling.
- ◆ Identifying infrastructure deficiencies and under-utilisation and closing these gaps on a priority basis - while ensuring that the existing infrastructure is fully utilised.
- ◆ Identifying equipment and supplies required along with skill development and maintenance arrangements needed - while ensuring that all existing equipment are fully utilised (or condemned or returned).
- ◆ Redefining work allocations of all staff (who are increasingly multi-skilled) based on needed manpower/skills in each facility.
- ◆ Integration of all institutions of indigenous systems of medicine in the block into the block level plan and building skill sets needed for them. Such a measure should contribute effectively to public health goals.
- ◆ In synergy with all the above, ensuring that the services delivery in the block, in every facility keeps improving, both in quantity and quality.
- ◆ Evaluation of progress towards physical and quality goals at the end of the year based on indicators developed by the block team.

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decentralisation. It would also build up administrative and planning capabilities in the block medical officer who is at the cutting edge of all programme implementation. It would also ensure full utilisation of existing manpower and infrastructure and equipment. It would also involve the janpad panchayat and build its capabilities.

We note that all the steps in this are possible within the existing policy frameworks and what one requires is the sanction to proceed block by block in a comprehensive manner.

STRATEGY - II

INTERMEDIATE LEVEL OF OPERATIONALISATION : THE ADMINSTRATIVE

Many other recommendations of this study are amenable to immediate administrative action and should be converted into specific proposals for the purpose. In some instances it may require some further consultation with stake holders in the proposed changes though in most areas given below they have readily agreed to these measures in the dialogues that have taken place. The main areas where such administrative action is possible are given in Chapter 12.

STRATEGY - III

HIGHEST LEVEL OF OPERATIONALISATION THE LEGISLATIVE

In a democracy the highest level is always the political level. However, issues like norms of service delivery or issues of human resource development do not from part of the mainstream political discourse except as knee jerk reactions of a populist sort. Thus the compulsions on political forces cutting across ideologies

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We must recognise that there is already the widest possible consensus across all ideologies and economic philosophies - that health care for the poor is the responsibility of the state. The government of Chhattisgarh shares this commitment in no small measure

and parties are such that there is considerable "public pressure and support" for certain types of interventions like building a 100 bedded hospital, while on the other hand most 30 bedded hospitals go underutilised. The non-recurrent component of an AIIMS hospital costs as much as the entire state health annual budget, but it can win across party political support, but not a fair transfer policy that could ensure that remote areas are better staffed. Public private partnerships for advanced cardiology centers are easier to realise than partnerships at local levels for basic laboratory or midwifery services.

We must recognise that there is already the widest possible consensus across all ideologies and economic philosophies - that health care for the poor is the responsibility of the state. The government of Chhattisgarh shares this commitment in no small measure and as the events of the last few years show is willing to follow through with bold initiatives. However, there are political compulsions that influence the current state of public health policy and these compulsions are such that any administrative action can be too easily reversed by immediate factors and personalities and their preferences. One also cannot posit that the administrative mechanisms of a particular period have a permanence across new administrative dispensations.

Faced with a set of seemingly intransigent problems of governance that defy attempts to reform the public health system, administrators are increasingly looking at options that pull the government out of public health care provisioning altogether- confining it to health care financing targeting the poor.

Faced with a set of seemingly intransigent problems of governance that defy attempts to reform the public health system, administrators are increasingly looking at options that pull the government out of public health care provisioning altogether- confining it to health care financing targeting the poor. The three major forms this takes are - public private partnerships, public civil society partnerships in service delivery, and private

provisioning of health care services with public financing or insurance.

The experience with private free market provisioning and social insurance or reimbursement for the poor is too scanty to reach a firm conclusion. This third option is the easiest to declare but in the current context would be the most iniquitous. Given the nature of governance, it is unlikely that in the current social context the poor would be able to secure their entitlements. Moreover, the possibilities of being able to regulate the private sector on either ethical or cost considerations remain remote. Also, since the poverty line is set so low, any meaningful definition of the poor would cover at least 70% of the population at which coverage, public provisioning would be cheaper.

Public private partnerships and civil society partnerships, as delivery mechanisms to reach the service delivery norms of a particular facility level, are more feasible. However, the same problems of governance that undermine the public health system would after a short lag period for learning, undermine such public private partnerships too. They would do so by vitiating the process of selection of partnerships, the monitoring of such relationships, and the negotiation of costs while making kickbacks and commissions so much easier. Even if we start with a number of ethical quality players, the problems of governance would quickly select out the worst amongst them. The point we are making is that a political problem cannot be addressed merely by administrative mechanisms - they must admit of a political solution. Whether it is public provisioning, or private provisioning with public financing or public private partnerships they all would fail unless the problems of governance are

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Whether it is public provisioning, or private provisioning with public financing or public private partnerships they all would fail unless the problems of governance are attended to. Political decentralisation is one approach to reform in governance. Another initiative that needs to proceed in parallel is the legislative.

In the absence of such legal guidelines every case of denial of the right to health care services would appear to be the individual blame of the concerned doctor or staff and the systemic failures would go unchallenged and administrative and political accountability would be limited.

attended to. Political decentralisation is one approach to reform in governance. Another initiative that needs to proceed in parallel is the legislative. By such a legislative initiative administrators and civil society trying for health sector reform could be strengthened and the judiciary would be able to enforce the provision of health care delivery as a basic human right.

The committee therefore recommends the enactment of a suitable legislation called the Public Health and Health Services Act of the state of Chhattisgarh.

India is a signatory to a number of international covenants on health as a human right. The directive principles of the Indian constitution also provide for this right. Moreover, the Supreme Court has held that the government has a constitutional obligation to provide health facilities (State Of Punjab vs. Mohinder Singh Chawla (1997) 2SSC83,) and therefore to maintain adequate health services (State of Punjab vs. RS Bagga (1998) 4SSC 177). The need is to take this further with a codification of what adequate health services are and the minimum conditionalities of a public health care system that can be said to be fulfilling the obligation of the state. In the absence of such guidelines, every case of denial of the right to health care services would appear to be the individual blame of the concerned doctor or staff and the systemic failures would go unchallenged and administrative and political accountability would be limited.

A 'Public Health and Health Services Act' however is enforceable while retaining considerable administrative and political flexibility in how it is implemented. Such a public health services act would:

- ◆ Define a mechanism for laying down, and periodically revising, the norms of health services and facilities and supplies that the government would provide at every level- such that it is compatible with existing Supreme Court rulings and the right to life. Flowing from this would be the needs of the workforce, infrastructure, drugs, supplies and equipment needed at each facility which would have to be ensured.
- ◆ Define core administrative mechanisms that must be in place for ensuring that each facility has the workforce, infrastructure and supplies it needs and that quality of care standards are laid down and monitored, thereby ensuring effectiveness and accountability of the public health system.
- ◆ Define the regulatory mechanisms for ensuring the quality of care and effectiveness of care and ensuring the ethical nature of such services whether it be provided by the public sector or through public private partnerships.
- ◆ Include mechanisms of civil society oversight over the system understanding that health is too important and too close to everyone's lives to be left to the workings of a department alone.
- ◆ Codify the state's commitment to a community health worker programme so as to provide basic health awareness and access to minimum essential drugs and services at the habitation level.
- ◆ Define a broad policy for encouraging the provision of ethical care by the private sector in health so that its ethical and rational growth is encouraged and there is some measure of access to weaker sections of society.
- ◆ Define the vulnerable marginalised sections

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The right of a citizen to enjoy basic health services would come to imply for example, the right of an employee to a non discriminatory transfer policy and the right to have a transparent and efficient purchases policy.

Through a public health & health services act, the rights of citizens to basic health care, now implicit will be made explicit and judiciable and the issues of governance that deny a strong public health system would be brought into public scrutiny and redressal mechanisms.

which have special health care needs (eg - mentally affected patients, or homeless indigent etc and for whom the norms and mechanisms of services delivery have to be explicitly stated and monitored).

The creation of such an act requires a close cooperation with a wide range of public health expertise and legal minds together with an active role for civil society. The passing of such an act by the state assembly would also help to sensitise the legislature to the issues of health sector reform. The right of a citizen to enjoy basic health services would come to imply for example, the right of an employee to a non discriminatory transfer policy and the right to have a transparent and efficient purchases policy. Such policies are the preconditions of strengthening public health systems but unfortunately they do not even form part of the public discourse which remains stuck at blaming doctors for not serving at rural areas or not having high enough a budget allocation for drugs, all of which are issues but hardly the core of the problem. Through a public health & health services act, the rights of citizens to basic health care, now implicit will be made explicit and judiciable and the issues of governance that deny a strong public health system would be brought into public

In Conclusion

We have no illusions about the immediate possibilities of implementation of all of our recommendations and indeed they must have a much wider public discussion before they are accepted. But faced with such challenges to public health as Chhattisgarh represents we must at first let our imagination soar. For as one philosopher put it - "what differentiates the best of bees from the worst of architects is that the architect first erects the structure in his imagination before he erects it in reality."

We have in our own modest way - the worst of architects perhaps tried to erect such a structure in the collective imagination so that it can provide grounds for optimism.

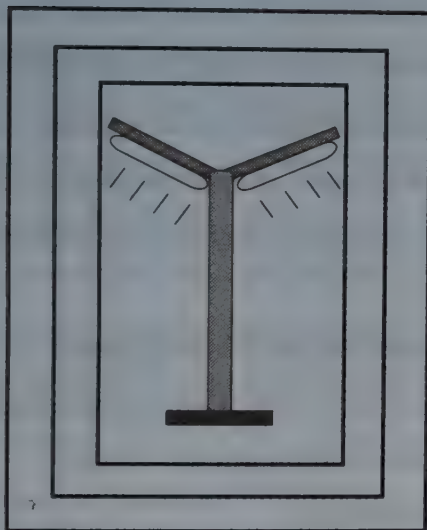
We feel the need to demonstrate, even at the conceptual level, that it is possible to have a pragmatic approach towards building a state of Chhattisgarh where as the Bhore Committee report declared in the opening sentence of its preamble, way back in 1946 "No citizen is denied an adequate quality of health care merely because of his or her inability to pay for it."

And the core content of such an approach is a strengthened public health system.



Chapter - XII

Recommendations For Immediate Implementation - A Short-list



From the many recommendations that this study makes the stakeholder dialogues helped us to shortlist a few. These few, that were prioritised as recommendations for immediate implementation, are listed in this chapter..

Recommendations For Immediate Implementation - A Short-list

(Prepared on the basis of the Stakeholders Dialogues)

- **Making the Community Health Centre, Primary Health Centre and Sub Health Centre Effective**
 - ◆ **Creating a Cadre of Multi-skilled Paramedical Workers**

Today more than half of the posts of paramedical workers in a PHC are vacant. However those who are posted there are often under-worked. A dresser posted in a PHC hardly ever gets more than 2 to 3 patients a day. On the other hand the PHC is not able to perform even routine laboratory tests because it does not have a laboratory technician. Multi-skilling of paramedical workers is therefore recommended, so that the entire package of services can be delivered in a PHC using the existing manpower.
 - ◆ **Gradually replacing the Male Health Worker with the Female Health Worker**

There are large vacancies of Male Health Workers in the State. Our study shows that the Male Health Worker essentially works as a support to the Female Health Worker. Female Health Worker performs most of the Public Health tasks. The need for having two Female Health Workers in each HSC has long been felt. It is therefore recommended that all vacant posts of Male Health Workers be filled up with Female Health Workers, and the cadre of Male Health Workers be declared a "dying cadre". Eventually each HSC will have only two Female Health Workers and no Male Health Worker.
 - ◆ **Creating a women employees' assistance cell at the district level**

A women employees' assistance cell should be created at the district level, to address the personal security issues of female staff especially the female multipurpose worker.
 - ◆ **Provisioning for a minimum package of Services**

A minimum package of services has been defined for each level in the detailed report. (see annexure -2) It is recommended that micro-planning be carried out for each HSC, PHC, and CHC to identify infrastructure, manpower, and equipment gaps in each centre, and resources be made available to the Districts to fill these gaps, and make the minimum package of services available in each centre. Though the detailed cost can be worked out only after the micro-planning, it is estimated that the cost will be approximately Rs 20 lakh per block. The Report calls this the EQUIP (Enhancing Quality in Primary Health) programme. EQUIP envisages that in addition to closing the "hardware gaps" the requisite, training, motivational and team building inputs would also be provided.
 - ◆ **Building up laboratory services**

At present laboratory services are almost non-existent at the PHC level. Laboratory services at

the PHC level should be based on multi-skilled workers and at the CHC level with qualified laboratory technicians. At both levels we recommend expanding the set of diagnostics as laid down in recommended norms of service delivery for every level with public private partnerships to fill in gaps where needed.

◆ **Logistics Support for Consumables**

It was found in the study that the management of logistics for medicines, and consumables is very poor. As a result many essential medicines, and consumables were not available in the HSCs, PHCs and CHCs. It is therefore recommended that a transparent and effective mechanism should be adopted for management of supplies. A mechanism similar to that followed in Tamil Nadu by TNMSC could be followed.

◆ **Multi-Skilling of doctors for Emergency Obstetric Care**

The clinical skill-sets- especially as related to emergency obstetric care, needed in a CHC should be defined and a programme of training doctors so that in a time bound manner all CHCs have the desired skill-sets should be initiated.

□ **A fair transfer and promotion policy**

It was noted during the study that the morale of the workforce is very low specially due to non-transparent and sometimes patently discriminative transfer and promotions procedures. It was therefore thought that a fair and transparent policy on these matters is necessary. Major recommendations in this regard are: -

- ◆ Transfers should be done at the district and state level by **district and state level tribunals**. All staff should serve for roughly equal time in postings categorised as of being of three levels of difficulty. Places of postings should be categorised into grade A, B and C according to the increasing level of difficulty. Employees may even be allowed a choice in the matter postings within the same grade of difficulty.
- ◆ Reducing pressures for transfer by making MPW selection into a block level cadre and other category selection including medical officers other than class I officers into district cadres.
- ◆ One time bound promotion for all cadres. However 25% of posts of the supervisor cadre should be reserved for a fast track promotion based on merit, and willingness to work in difficult areas.
- ◆ For medical officers adopting a promotions policy for class I doctors, consistent with two alternative career plan options. One leading to an administrative work definitions and another to more clinical work. Thus we should have two separate streams at class-1 level and above, one clinical and the other administrative. Those who are good clinicians, but are not interested in administration should be given a career choice in the clinical stream with sufficient promotion opportunities. Those who choose the administrative stream, should receive good training in administrative and management matters, and should also have equally good promotion

opportunities.

- ◆ Designating the block medical officer as a distinct cadre, and entry point into an administrative cadre with well-defined job allocation and administrative and financial powers. Ensuring that all of them receive a three-month management-skill package.
- ◆ Constitution the district team as made up of a Chief medical officer along with four full time programme officers who are part of the administrative cadre and serve as deputy CMOs. In parallel to this ensuring that all these posts are regular appointments with tenure and that there are state level support systems in place.

□ **Capacity Building and Human Resource Development**

- ◆ Adopting the training policy for all staff whose main component is ensuring that all staff receives 15 days of in-service training every two years so as to ensure that minimum competencies for that facility level are present and updated. The requirement of training infrastructure is defined by this need.
- ◆ Initiating an innovative CME programme as the main stay of training for the medical officers along with a mechanism of managing the CME.
- ◆ Disseminating and training medical officers and specialists on standard treatment guidelines as well as the norms of clinical services provision that the government is committed to.

□ **Other recommendations**

- ◆ Building a GIS based programme displaying facility location in relation to habitations so as to assist block and district offices in optimising physical access to facilities.
- ◆ Revising the referral system with a strong feedback arrangement with enhanced communication facilities and linking it with a block level ambulance programme so as to improve the effectiveness and credibility of the different facilities.
- ◆ Integrating the ISM manpower and infrastructure towards achieving public health goals by sharing infrastructure at the sector level and training and allocation of public health functions of the sub-centre to ISM institutions.
- ◆ Restructuring state health society (including re-thinking the need for its continuation -in comparison to directly functioning all programmes a part of the state budget) to make it more functional and accountable.
- ◆ Strengthening state level function by de-concentration and decentralisation and a more distributed work allocation between expanded numbers of senior personnel. Senior cadre should have a guaranteed tenure, a clear work profile and a personally affixed sector development goal that they have to meet in this period along with adequate powers that enable them to take initiatives where needed.

Annexures

ANNEXURE - 1

A Study on Organisational Culture and Motivational Factors in the Health System of Chattisgarh

by Dr Vinod Arora, Dean, Indian Institute of Health management and Research, Jaipur

The various terms used in the context of organizational culture are values, ethics, beliefs, ethos, climate, environment, atmosphere, and culture. The culture-related concepts can also be seen as multi-level concepts. For the present purpose, organizational culture is studied up to two levels: organizational ethos and climate. The core (first level) comprises the values, which give a distinct identity to a group. This is the ethos of the group. The second level concept is climate, which can be defined as the perceived attributes of an organization and its sub-systems as reflected in the way an organization deals with its members, groups, and issues. The emphasis is mainly on perceived attributes and the working of sub-systems.

Organisational culture (Ethos)

The eight important values relevant to institution building are openness, confrontation, trust, authenticity, proaction, autonomy, collaboration and experimentation. In addition to being an acronym for these values, OCTAPACE is a meaningful term, indicating eight (octa) steps (pace) to create functional ethos. The instrument OCTAPACE gives a profile based on eight values as described below:

Openness

"Openness" can be defined as a spontaneous expression of feelings and thoughts, and the sharing of these without defensiveness. Openness is in both directions, receiving and giving. These may relate to ideas (including suggestions), feedback (including criticism), and feelings. Openness may also mean spatial openness, in terms of accessibility.

Confrontation

"Confrontation" can be defined as facing rather than shying away from problems. It also implies deeper analysis or interpersonal problems. All this involves taking up challenges. The term "confrontation": if used with some reservation means putting up a front, as contrasted with turning one's back (escaping) to the problem. A better term would be confrontation and exploration (CE).

Trust

Here, "trust" is not used in the moral sense. It is reflected in maintaining the confidentiality of information shared by others, and in not misusing it. It is also reflected in a sense of assurance that others will help, when such help is needed and will honour mutual commitments and obligations. Trust is also reflected in accepting what another person says at face value, and not searching for ulterior motives. Trust is an extremely important ingredient in the institution building processes.

Authenticity

"Authenticity" is the congruence between what one feels, says and does. It is reflected in owning up one's mistakes, and in unreserved sharing of feelings. Authenticity is closer to openness.

Proaction

"Proaction" means taking the initiative, preparing and taking preventive action, and calculating the payoffs of an alternative course before taking action. The term proact can be contrasted with the term react. In the latter, action is in response to (and in the pattern of) an act from some source, while in the former the action is taken independent of the source. Proactivity gives initiative to the person to start a new process or set a new pattern of behaviour. In reactive behaviour the initiative lies with the source and the person merely acts according to the pattern set by that source.

Autonomy

"Autonomy" is using and giving freedom to plan and act in one's own sphere. It means respecting and encouraging individual and role autonomy. It develops mutual respect and is likely to result in willingness to take on responsibility, individual initiative, and better succession planning.

Collaboration

"Collaboration" is giving help to, and asking for help from, others. It means working together (individuals and groups) to solve problems and team spirit.

Experimenting

"Experimenting" means using and encouraging innovative approaches to solve problems; using feedback for improving, taking a fresh look at things, and encouraging creativity.

To measure the Organisational Culture, the instrument OCTAPACE was administered. In all 74 respondents filled the instrument. The results are shown in the table below.

Table : Means and Standard Deviations of OCTAPACE for the development of Health and Family Welfare, Govt. of Chattisgarh
N = 74

Values	Mean Value	Range of scores		Norms*		Remarks
		Min.	Max.	Low	High	
Openness	15	9	20	13	17	Medium
Confrontation	14	9	20	13	17	Medium
Trust	14	10	18	13	17	Medium
Authenticity	12	8	18	10	14	Medium
Proaction	16	10	20	13	17	Medium
Autonomy	12	8	18	11	16	Medium
Collaboration	14	10	20	13	17	Medium
Experimentation	14	6	19	11	16	Medium

*Ref: Pareek, Udai (2002) Training Instruments in HRD and OD. Tata McGraw-Hill, New Delhi

Findings

All the aspects of OCTAPACE have been found in the range of medium. None of the aspects was found in the low category which is a healthy sign. There is a tremendous potential to increase all the 8 dimensions of OCTAPACE from medium to high level.

Suggestions

- There should be genuine sharing of information, feelings, and thoughts by everyone which will help in improving the openness
- Every organization has interpersonal problems. These problems should be deeply analysed and efforts should be made to find out the solution to these problems rather than suffering them. Employees should be encouraged to deal with inherent challenges in the work situations. This will help increase confrontation.
- People in the organisation should offer moral support and help to employees and colleagues in a crisis. The interpersonal contact and support among people should be increased which will help in increasing level of trust
- People in the organization should learn owing up their mistakes and improve upon them. The gap between feelings and expressed behaviour should be minimized for making coordinational relations. Polite lie should be preferred to telling one an unpleasant truth. By doing so, the level of authenticity can be increased.
- People in the organization should learn to take preventive action on most of the matters. It will help increase in proaction.
- Efforts should be made by the people to take independent action on most of the aspects relating to their jobs. For making the management more effective, there is a need to increase supervision and direction. For planning their work, employees should be given autonomy, as it motivates them. This will help to increase the aspect of autonomy.
- The team-work should be promoted in order to bring the team spirit among the people. People in the organization should accept and appreciate the help offered by others and should be more concerned about performing at least the minimum rather than being worried about petty organizational issues. This will help increasing collaboration.
- Employees should be encouraged to take initiatives and the organizations vitality should be maintained by trying out new things. It will help in increasing experimentation.

Organisational Climate

To measure the climate of the Department, MAO-C was administered to 74 respondents. The instrument employs 12 organizational dimensions with six motives. All the 12 dimensions and six motives are discussed in detail.

Motives:

- Achievement motive is characterized by concern for excellence; competition in terms of the standards set by others or by oneself; the setting of challenging goals, for oneself, awareness of the obstacles that might be encountered in attempting to achieve these goals, and persistence in trying alternative paths to one's goals.
- Expert Influence motive is characterized by a concern for making an impact on others; a desire to make people do what one thinks is right; and an urge to change situations and develop people.
- Control is characterized by a concern for orderliness; a desire to be and stay informed; an urge to monitor events and to take corrective action when needed; and a need to display personal power.
- Extension is characterized by a concern for others; interest in super ordinate goals; and an urge to be relevant and useful to large groups, including society
- Dependency is characterized by a desire for the assistance of others in developing oneself; a need to check with significant others (those who are more knowledgeable or have higher status, experts, close associates, etc.); a tendency to submit ideas or proposals for approval and an urge to maintain a relationship based on the other person's approval.
- Affiliation is characterized by a concern for establishing and maintaining close, personal relationships; an emphasis on friendships; and a tendency to express one's emotions.

Organisation Processes

- Orientation is the main concern of the members of an organization. If the dominant orientation or concern is to adhere to established rules, the climate will be characterized by control. On the other hand, if the orientation is to excel, the climate will be characterized by achievement.
- Interpersonal Relationship An organisation's interpersonal relations are reflected in the way of informal groups are formed. If groups are formed for the purpose of protecting their own interests, cliques may develop and a climate of control may result; similarly, if people tend to develop informal relationships with their supervisors, a climate of dependency may result.
- Supervision Supervisory practices contribute significantly to climate and atmosphere. If supervisors focus on helping their subordinates to improve personal skills and their chances of advancement, a climate that is characterized by the extension motive may result. If supervisors are more concerned with maintaining good relations with their subordinates, a climate characterized by the affiliation motive may result.
- Problem Management Problems can be seen as challenges or irritants. The supervisor alone, or the supervisor and the subordinate (s) concerned jointly can solve them, or they can be referred to a higher level. These different perspectives and ways of handling problems contribute to the creation of organizational climate and atmosphere.
- Management of mistakes A supervisor's attitude toward a subordinate's mistakes develops the organizational orientation, which is generally one of annoyance, concern or tolerance. An organization's approach to mistakes influences the climate and atmosphere.
- Conflict Management Conflicts may be seen as an embarrassing annoyance to be covered up, or as problems to be solved. The process of dealing with conflicts has a significant effect on the climate and atmosphere, just like the handling of problems or mistakes.
- Communication: Communication is concerned with the flow of information: its direction (top-down, bottom-up, horizontal), its dispersement (selectively or to everyone concerned), its mode (formal or informal), and its type (instructions or feedback on the state of affairs).
- Decision Making An organization's approach to decision making can be focused on maintaining good relations or on achieving results. In addition, the issue of who makes the decisions is important: it could be people high in the hierarchy, experts, or those involved in the matters about which decision are made. These elements of decision-making are relevant to the establishment of a particular climate or atmosphere. The issue of who is trusted by the management and to what degree, is also relevant.
- Trust The degree of trust or its absence among various members and groups in the organization affects the climate. The issue of who is trusted by the management and to what degree, is also relevant.
- Management of Rewards Rewards reinforce specific behaviours, thereby arousing and sustaining specific motives. Consequently, what is rewarded in an organization influences the organization climate.
- Risk Taking How people respond to risks, and whose help is sought in situations involving risk, are important determinants of climate.
- Innovation and Change Who initiates change, how change and innovations are perceived and how change is implemented are all critical in establishing climate.

Findings

The respondents believe that overall, "dependency" is the dominant motive that drives the organization while the control" motive is the back up one. On the whole, the department has clear cut channels of communication and is controlled by a few people who ultimately make all the decisions. The same is true of three organizational dimension i.e, orientation, management of mistakes, and communication.

Two dimensions – interpersonal-relationship and problem-management are characterized by "dependency" (dominant) and followed by "affiliation". This shows that the top managers control the organizations and depend upon their own in-group members, who are extremely loyal to these managers.

Another three organizational dimensions – supervision, conflict management, and trust – are characterized by "control" (dominant) and "expert influence" (backup) . It means the Department is hierarchical but places more emphasis on good relations among employees than on the results. Informal groups based on relationship are relatively more important.

In the Department, "dependency" (dominant) and "expert influence" (backup) characterize decision making and management of rewards. This shows that the Department has a hierarchy. Most of the decisions are made at the higher level in consultation with the experts. However, a few people, who ultimately make all the decisions, control the Department.

On the risk taking dimension, the Department values maintenance of friendly relations among members and shies away from using approaches which seem to be risky. Only a few persons (one or two) make most of the decisions. The climate in relation to innovations and change has "control" as a dominant motive backed by "expert influence". It again confirms strong bureaucracy in the Department where, though specialists' opinions are valued, rules are treated as being more important.

Out of the twelve dimensions of organizational climate, seven are driven by the dependency motive predominantly. Except for influence, all the perceived motives, either dominant or back up, are dysfunctional for an organization and retard the achievement of results.

It clearly brings out that the efforts should be made to reduce the dysfunctional climates (dependency, control and affiliation) and increase the functional ones (achievement, expert influence and extension) for all the dimensions in the department.

Most of the key recommendations from this study have been included in the main body of the study report. One important suggestions that was not included but with which the study group agrees is a mission statement:

Mission: There is no written mission statement. People have some perception but it is quite vague and everyone has his own perception. A Mission statement should be prepared, adopted and pasted in all the Health Institutions.

ANNEXURE - 2

CHHATTISGARH'S GRADED HEALTH SERVICE NORMS

CLINICAL SERVICES TO BE RENDERED AT DIFFERENT LEVELS OF PUBLIC HEALTH SYSTEM;

The list of services below is the recommended norms. The understanding is that each block would make its own norms according to manpower and equipment available and would work towards the ideal norms (as suggested below) over this five-year plan period.

The standard treatment guidelines to be issued will give details of drugs and tests needed for each specific service.

Note that all cases shown under PHC would be referred to CHC level for confirming diagnosis where diagnosis is in doubt; for inadequate response to treatment at PHC level or when hospitalisation is indicated.

Similarly all cases shown under CHC level would be referred to District hospital for confirming diagnosis where needed; for inadequate response at CHC level or when technologically more demanding hospitalisation is indicated.

An* indicates that this disease can be diagnosed and managed at this level once a diagnostic test or consultation is taken from next higher level- for which a two way referral arrangement is required. Two** indicates that diagnosis and treatment plan is to be established at this facility but subsequent follow up may be at lower facility. Grey Shaded rows indicate the diagnostic capability and other necessary facilities that should be available at that particular level, to provide specified level of service.

The list of service given below states the lowest level at which each service is available. It follows that specific service is available in all levels.

A. GENERAL MEDICINE & PAEDIATRICS

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Viral Infection	<ul style="list-style-type: none"> • Simple fevers • Eruptive fevers: • Chicken Pox, • Measles, • Mumps 	<ul style="list-style-type: none"> • Fever with complications [e.g. pneumonia] • Viral encephalitis 	<ul style="list-style-type: none"> • Poliomyelitis - suspected
X-ray			
Bacterial Infection	<ul style="list-style-type: none"> • Typhoid* (presumptive) • Filariasis • Pulmonary Tuberculosis • Leprosy (for diarrhoea pneumonia, UTI etc. see appropriate system) 	<ul style="list-style-type: none"> • Typhoid fever • Diphtheria • Pertussis • Leptospirosis* • Acute Meningitis* • Extrapulmonary tuberculosis** • Lepra reactions • Tetanus 	<ul style="list-style-type: none"> • Tetanus
	<ul style="list-style-type: none"> • Microscopy- • Blood smear; • Sputum AFB • CSF examination for cells, • Grams stain 	<ul style="list-style-type: none"> • Widal test • Csf examination including biochemistry and stains 	<ul style="list-style-type: none"> • Culture • Serology • Histopathology • Ventilatory support
Protozoal	<ul style="list-style-type: none"> • Malaria- simple 	<ul style="list-style-type: none"> • Malaria complicated • Kala-azar 	
	<ul style="list-style-type: none"> • Blood smear examination- microscopy 		
STD	<ul style="list-style-type: none"> • Syphilis* • Gonorrhoea* 	<ul style="list-style-type: none"> • All forms of syphilis • All cases of chancres and chancroids, • Urethritis • HIV positive cases, not complicated 	<ul style="list-style-type: none"> • AIDS disease
	<ul style="list-style-type: none"> • Urine microscopy 	<ul style="list-style-type: none"> • HIV test for AIDS • VDRL 	<ul style="list-style-type: none"> • Serology

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Poisoning cases	<ul style="list-style-type: none">• General measures for poisoning• Initiate treatment in all, and manage mild cases fully	<ul style="list-style-type: none">• Organophosphorus• Other insecticide• Opioid• All others	<ul style="list-style-type: none">• All cases for Haemodialysis.
		<ul style="list-style-type: none">• Ventilatory support	<ul style="list-style-type: none">• Haemodialysis.
Animal Bites	<ul style="list-style-type: none">• Snake bite,• Dog bite & other animal Bite- first contact care	<ul style="list-style-type: none">• Snake bite with signs of envenomation	<ul style="list-style-type: none">• Snake Bite with ARF or DIC or respiratory paralysis
	<ul style="list-style-type: none">• Bleeding time• Clotting time	<ul style="list-style-type: none">• Bleeding time, clotting time,• Basic ventilatory support	<ul style="list-style-type: none">• FDP; adequate ventilatory support
Environmental disorder	<ul style="list-style-type: none">• Heat Syndromes,• Electrical Injury cases	<ul style="list-style-type: none">• Heat stroke	
Gastro-intestinal Tract Disorder	<ul style="list-style-type: none">• Gastroenteritis- including cholera, algid malaria• Bacillary Dysentery• Viral hepatitis• Enteric fever*• Acid peptic disease• Alcoholic Hepatitis• Amoebic liver abscess where clinically evident	<ul style="list-style-type: none">• Jaundice other than viral hepatitis;• Chronic Active Hepatitis*;• All Liver abscess ;• Hepato-cellular failure• G I haemorrhage;• Ruptured Oesophageal varices	<ul style="list-style-type: none">• Malignancies• Fulminant Hepatic failure and coma
	<ul style="list-style-type: none">• Stool microscopy• Blood counts, BSE	<ul style="list-style-type: none">• Liver function tests• HbsAg• Ultrasound• Liver biopsy*	<ul style="list-style-type: none">• Blood and stool culture• Endoscopy• Liver histopathology

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Respiratory Disorder	<ul style="list-style-type: none"> • Pulmonary Tuberculosis, • Bronchial asthma pneumonia, Broncho-pneumonia, • Lung abscess • Chronic Bronchitis and emphysema • Pleural effusion- • Emergency care alone in Pneumothorax Hydro -pneumothorax 	<ul style="list-style-type: none"> • All cases referred from PHC Plus • Empyema chest • COPD or any of the above with threatened respiratory failure 	<ul style="list-style-type: none"> • All cases referred. from CHC • Plus malignancies • Plus those requiring prolonged ventilatory care
	<ul style="list-style-type: none"> • Sputum Grams stain and AFB stain microscopy • Blood counts • Nebulizer • Oxygen 	<ul style="list-style-type: none"> • X-rays • Basic Pulmonary function tests • Ultrasound • Pleural fluid • Biochemistry • Basic ventilatory care 	<ul style="list-style-type: none"> • Culture • Bronchoscopy • Adequate ventilatory care
Cardio- Vascular Disorder	<ul style="list-style-type: none"> • Hypertension • Rheumatic fever* • Rheumatic Valvular Disease* • Angina* 	<ul style="list-style-type: none"> • Acute myocardial Infarction • Angina** and unstable angina • Hypertensive Encephalopathy • T I A • cardiomyopathy • Pericardial effusion 	<ul style="list-style-type: none"> • Acute myocardial infarction with complications- • Diagnosis of congenital health disease
	<ul style="list-style-type: none"> • Blood pressure instrument 	<ul style="list-style-type: none"> • ECG • Ultrasound • X-rays • Serum enzymes- CPK-MB 	<ul style="list-style-type: none"> • Intensive cardiac care unit • Treadmill stress test
Haematological disorders	<ul style="list-style-type: none"> • Iron Deficiency Anaemia • Sickle Cell anaemia 		<ul style="list-style-type: none"> • Purpura* • Leukemia* • Aplastic Anaemia* • Haemolytic Anaemia*
	<ul style="list-style-type: none"> • Blood counts, blood Hb, peripheral smear, • Sickling test 	<ul style="list-style-type: none"> • Bleeding time • Coagulation tests, 	<ul style="list-style-type: none"> • Bone marrow biopsy • Histopathology • Range of coagulation tests

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Renal disorder	<ul style="list-style-type: none"> • UTI • Acute Pyelonephritis • Acute Glomerulonephritis 	<ul style="list-style-type: none"> • Nephrotic Syndrome • Conservative management of ARF • Chronic renal failure supportive care 	<ul style="list-style-type: none"> • Acute Renal failure cases requiring Haemodialysis
	<ul style="list-style-type: none"> • Urine examination including microscopy 	<ul style="list-style-type: none"> • Renal biopsy* • 24 Hr urine examination • Blood creatinine, uric acid, serum proteins, 	<ul style="list-style-type: none"> • Histopathology • Culture facilities • Urinary electrolytes • Serum electrolytes
Endocrine disorder	<ul style="list-style-type: none"> • Diabetes (uncomplicated) • Hypothyroid* or hyperthyroid* • Euthyroid goitre 	<ul style="list-style-type: none"> • Diabetic ketoacidosis • Thyrotoxicosis** • Myxoedema crisis** • Addison's disease • Cushing's disease 	<ul style="list-style-type: none"> • Other endocrine disorders
	<ul style="list-style-type: none"> • Urine sugar, ketones 	<ul style="list-style-type: none"> • T3, T4, TSH* • Blood sugar • Ultrasound • Blood electrolytes, 	<ul style="list-style-type: none"> • Serum cortisol; other serum hormones
Musculo-Skeletal disorder	<ul style="list-style-type: none"> • Osteo-arthritis Uncomplicated • Rheumatic arthritis • Rheumatoid arthritis 	<ul style="list-style-type: none"> • Complicated rheumatoid arthritis • All other arthritis. 	<ul style="list-style-type: none"> • Severe arthritis non responsive to first line drugs
		<ul style="list-style-type: none"> • ASLO; Rheumatic factor 	<ul style="list-style-type: none"> • Synovial fluid examination
Neurology	<ul style="list-style-type: none"> • Epilepsy* • Established stroke • Migraine 	<ul style="list-style-type: none"> • Non responsive epilepsy • Recent stroke 	<ul style="list-style-type: none"> • Acute flaccid paralysis • Other neurological conditions
			<ul style="list-style-type: none"> • EEG, CT scan
Paediatric disorders	<ul style="list-style-type: none"> • All as indicated for medicine above plus • Low Birth weight babies – above 1.5 kg • Malnutrition 	<ul style="list-style-type: none"> • All as indicated for medicine above plus • Low birth weight babies below 1.5 kg • Severe malnutrition requiring resuscitation measures • Complicated cases with stridor, wheezing and inability to feed or drink and unconscious patients. 	<ul style="list-style-type: none"> • All as indicated for medicine above plus • Congenital malformations, • Genetic diseases • Children requiring incubators, ventilation or prolonged hospitalization
		<ul style="list-style-type: none"> • Baby warmers 	<ul style="list-style-type: none"> • Neonatal care unit with incubators

B. SURGERY

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Basic Technique	<ul style="list-style-type: none"> • Incision & Drainage • Emergency patients of trauma etc. for Resuscitation & stabilization 	<ul style="list-style-type: none"> • Excision & Biopsy 	
Gastro Intestinal disorders		<ul style="list-style-type: none"> • Herniorrhaphy • Emergency Appendicectomy • Fistula • Piles • Fissure • Ano rectal Abscesses • Rectal prolapse 	<ul style="list-style-type: none"> • Exploratory Laparotomy • Obstructed Hernia • Chronic & acute Appendicitis • peptic perforation • Intestinal obstruction • Intussusception • Volvulus • Gastrojejunostomy • Drainage of abd. Abscess • Haemorrhoidectomy • Cholecystectomy
			<ul style="list-style-type: none"> • Proctoscopy, • Sigmoidoscopy, • Endoscopy, • Neonatal Surgery
Genito-Urinary disorders		<ul style="list-style-type: none"> • Acute Urinary Retention • Supra-pubic cystostomy • Hydrocoele • Circumcision • Vasectomy** 	<ul style="list-style-type: none"> • Ruptured Urethra & bladder • Nephrectomy. • Hypospadias • Cases requiring cystoscopy
Chest disorders	<ul style="list-style-type: none"> • Tracheostomy if possible – where indicated prior to referral 	<ul style="list-style-type: none"> • Pneumothorax, • Haemothorax, • Pyothorax: • Breast Abscess 	<ul style="list-style-type: none"> • Mastectomy (Ca. Breast) • Penetrating injury of chest
Head Injury	<ul style="list-style-type: none"> • refer to CHC 	<ul style="list-style-type: none"> • Observation to determine whether referral required 	<ul style="list-style-type: none"> • All head injuries
Burn Injury	<ul style="list-style-type: none"> • Minor burns- 	<ul style="list-style-type: none"> • Minor burns -upto 20%. 	<ul style="list-style-type: none"> • In burns ward above 40%

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Cancers	<ul style="list-style-type: none"> • First aid measures and arranging for proper transport 	<ul style="list-style-type: none"> • Biopsy to establish diagnosis 	<ul style="list-style-type: none"> • Surgery with • Chemotherapy. • Refer to tertiary level hospital for Radiotherapy.
Orthopaedic disorder	<ul style="list-style-type: none"> • Splinting • Other first aid required for shifting patients 	<ul style="list-style-type: none"> • Simple fracture plastering & • Reduction under GA • Shock resuscitation • Finger amputation • Dislocation under GA. 	<ul style="list-style-type: none"> • Lacerated injury of limbs. • Amputation • pin & plating and screw of both bone leg and hands • Prosthesis. • Open reduction of elbow. • Patellectomy • Skeletal traction. • Needle aspiration of joint & synovial fluid. • penetrating Rib Fracture • Refer to Tertiary level Hospital for Spinal Trauma

• X-ray

C. PSYCHIATRY, DERMATOLOGY, OPHTHALMOLOGY, ENT, DENTISTRY

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Mental Health Disorders	<ul style="list-style-type: none"> • Anxiety Neurosis • Depression • Acute Psychosis-emergency care 	<ul style="list-style-type: none"> • Psychoses • Bipolar disorders • Intoxication • Drug withdrawal cases. 	<ul style="list-style-type: none"> • All cases where diagnosis in doubt or poor response – needs counselling and care
Dermatological disorders	<ul style="list-style-type: none"> • Pediculosis • Impetigo • Scabies • Fungal infection esp. ring worm • Herpes Simplex • Herpes Zoster • Urticaria and Drug induced Allergies • Yaws 	<ul style="list-style-type: none"> • Psoriasis • Candidiasis • Eczema • Dermatitis 	<ul style="list-style-type: none"> • Diagnosis other than those listed earlier.
	<ul style="list-style-type: none"> • Skin scraping for microscopy 	<ul style="list-style-type: none"> • Microscopy 	<ul style="list-style-type: none"> • Culture facility • Histopathology
Ophthalmology	<ul style="list-style-type: none"> • Conjunctivitis • Dacryo-Cystitis • Night blindness • Cataract detection • Hordeolum externum • Refractive Errors-gross detection. • External FB removal 	<ul style="list-style-type: none"> • Corneal Ulcer, • Uveitis • Scleritis • Cataract surgery • Lacrimal fistula, • Abnormality of ocular motility. • Glaucoma • Any orbital disease 	<ul style="list-style-type: none"> • Disease of post segment of eyeball. • Orbital tumour. • Intra ocular F.B,
	<ul style="list-style-type: none"> • Vision chart- both near and far, • Torch, • Pinhole, • Ophthalmoscope 	<ul style="list-style-type: none"> • If ophthalmologist available slit lamp provided – or else in monthly visit to CHC 	<ul style="list-style-type: none"> • Cryoplasty, • Fluoroangiography, • USG.

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Ear, Nose throat Problems	<ul style="list-style-type: none"> • Wax • Furuncle • Perichondritis • Otitis externa • Otomycosis • ASOM • CSOM • Epistaxis • Rhinitis, viral, allergic, rhinitis • Sinusitis • Aphthous ulcers • Acute tonsillitis , pharyngitis 	<ul style="list-style-type: none"> • ASOM severe • CSOM unsafe type • Polypectomy; • Incision & Drainage of Retropharyngeal abscess and peritonsillar Abscess • Laryngitis, • Epiglottitis 	<ul style="list-style-type: none"> • Tonsillectomy, • Deviated nasal septum. • Tympanoplasty, • Stapedectomy • Rehabilitation & speech Therapy • Post traumatic Bleeding .or discharge – • Refer to tertiary Hospital any symptom of malignancy.
	<ul style="list-style-type: none"> • Ear speculum, Nasal speculum, torch, 	<ul style="list-style-type: none"> • Otoscope • General surgical expertise needed 	<ul style="list-style-type: none"> • Audiometry : ENT specialist needed
Dentistry	<ul style="list-style-type: none"> • Tooth aches • Caries tooth • Acute gingivitis 	<ul style="list-style-type: none"> • Filling & preservation of all Caries tooth, • Tooth Extraction, impaction & other minor surgery • All periodontal Diseases: • Scaling and Curettage ulcers of oral origin. 	<ul style="list-style-type: none"> • Artificial prosthesis. • Diag. of Oral Ca & other Neoplasms - reld.

In all the above areas each CHC receives a visit on a fixed day every month by a specialist. The specialist could be from private sector if none are available in public sector.

D. OBSTETRICS & GYNAECOLOGY

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Ante natal care	<ul style="list-style-type: none"> • Diagnosis of pregnancy • Normal antenatal care • Management of mild and moderate anaemia • Pre-eclampsia • Rhesus incompatibility detection, • Induction of labour • Emergency care in ante or post partum haemorrhage 	<ul style="list-style-type: none"> • All cases refd. from PHC as high risk cases. • Evacuation of retained products. • Laparotomy for Ectopic pregnancy, • Induced labour. • Prophylaxis for Rh incompatibility. • Management of haemorrhagia. • Management of severe anaemia. • Eclampsia. 	<ul style="list-style-type: none"> • Severe medical complications- jaundice, Heart disease, uncontrolled diabetes
	<ul style="list-style-type: none"> • Blood Hb, • Peripheral smear counts, • Urine examination • Pregnancy testing • Blood grouping • Suction apparatus 	<ul style="list-style-type: none"> • Ultrasound • Operation theatre and all accessories as needed for a caesarean section • Blood transfusion facilities, • forceps; 	
At child birth	<ul style="list-style-type: none"> • Normal Delivery 	<ul style="list-style-type: none"> • All cases needing Emergency Caesarian section or forceps Delivery. • Complicated delivery; (Obstructed Labour, Malpresentation etc.) • Maternal and foetal distress • Laparotomy for Ruptured uterus 	<ul style="list-style-type: none"> • Elective caesarean sections in certain high risk cases – like low placenta previa etc • Laparotomy for ruptured uterus. etc.

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Postpartum care	<ul style="list-style-type: none">• Normal Neonatal care.• Neonatal care pre-term upto 1.5 kg.• Puerperal fever• Contraception	<ul style="list-style-type: none">• All neonates less than 1.5kg weight.• Severe puerperal infections	
		<ul style="list-style-type: none">• baby warmer	<ul style="list-style-type: none">• Baby warmer and incubator
Abortion	<ul style="list-style-type: none">• Conservative treatment for threatened abortion	<ul style="list-style-type: none">• MTP;• D&C for incomplete abortion	<ul style="list-style-type: none">• Management for habitual abortion.
		<ul style="list-style-type: none">• D&C set,• Blood transfusion facilities,• operation theatre and accessories	
Vaginal and External Genitalia	<ul style="list-style-type: none">• Cervical erosion• Cervix Biopsy	<ul style="list-style-type: none">• Abscess Drainage• Excision of Bartholin's Cyst.• E.U.A	<ul style="list-style-type: none">• Vesico-vaginal Fistula (VVF)• Recto Vaginal fistula• Complete Perineal Tear (CPT)• Prolapse of Uterus• Pelvic floor repair.• Incontinence• Polypectomy,
	<ul style="list-style-type: none">• PAP smear*	<ul style="list-style-type: none">• Endometrial Biopsy.;• cervix biopsy*	<ul style="list-style-type: none">• Histopathology• Adequate surgical facilities
Menstrual irregularity	<ul style="list-style-type: none">• Presumptive treatment	<ul style="list-style-type: none">• Polymenorrhoea• Menorrhagia• Amenorrhoea: Diagnosis and D&C, Drug therapy	<ul style="list-style-type: none">• Myomectomy,• Hysterectomy
Malignancy			<ul style="list-style-type: none">• Ovarian Tumour*• Tumours of the• Reproductive Organs
	<ul style="list-style-type: none">• PAP smear*	<ul style="list-style-type: none">• Endometrial Biopsy.;• cervix biopsy*	<ul style="list-style-type: none">• Histopathology

Clinical Services related to :	PHC	CHC	District Hospital and all 100 bedded hospitals
Primary & secondary Infertility		<ul style="list-style-type: none"> • Dilatation & Curettage (D&C). • Tubal Insufflation 	
		<ul style="list-style-type: none"> • Semen analysis • laparoscope • Hystero - salpingiogram 	<ul style="list-style-type: none"> • Hormone tests*
Pelvic Inflammatory disease (P.I.D) and Reproductive Tract infection		<ul style="list-style-type: none"> • Detailed examination and specific treatment 	<ul style="list-style-type: none"> • Laparoscopic investigation
Contraception	<ul style="list-style-type: none"> • IUCD insertion • Condoms and diaphragm supply • Initiating and monitoring on OC pills • During Special visits tubectomy and vasectomy 	<ul style="list-style-type: none"> • Laparoscope tubectomy • Conventional tubectomy • Vasectomy 	<ul style="list-style-type: none"> • Refer All cases requiring Microsurgical Reconstruction of Fallopian Tube and Vas to tertiary centre

ANNEXURE - 3

Brief Proceedings of the Stakeholders Consultations on Workforce Development and Rationalisation of Health Services: November 7th to 9th, 2003.

The Consultations were organised over three days as follows

- ◆ November 7th- Consultation with Employees associations and some members of different sections of employees.
- ◆ November 8th –Consultation with senior administrators and senior health department officials. Also consultations with members of civil society active in the health sector. Group work to negotiate consensus positions on final recommendations.
- ◆ November 9th—Presentation to Chief Secretary and to Secretary, Government of India, Ministry of Family Welfare. And a summing up of the three days proceedings :

The consultations took the form of a presentation of the workforce report to the participants. The presentation to each section was made by Dr. T. Sundararaman, Director, SHRC, with the assistance of Dr. K. Madanagopal, Advisor, DSU. Then every person in the audience got an opportunity to present their views. Some associations also submitted their responses in writing. Key issues of divergence were identified for further discussion in small groups. On the second day four groups were formed around key issues. These groups tried to evolve a consensus on the key recommendations where there was any divergence.

On the third day the Workforce management report and the outcomes of the first two days of discussions were presented to the union secretary health Dr. Prasanna Hota and the chief secretary Mr. S. K. Mishra. In the afternoon there was a more detailed discussion on the role of panchayats.

Most of the participants endorsed the report and welcomed the dialogue-based approach to formulating a new health policy.

We give below some of the views expressed and describe some of the main points of discussion.

Employees Association And Invited Para medicals

The Chhattisgarh State Employees Union represented by seven persons over the three days emphasised the need to increase sub-centers and PHCs to meet the norms as per the year 2000 population. Equipment in the facilities and supplies also needed to improve. Even basic supplies like sterile syringes and needles, hemoglobinometers etc were often not available and this should be remedied. They stated that the employees should get the registers, notebooks and papers needed and not have to spend on it. Accommodation facilities were also needed. In rural areas each employee needed to be issued or given an allowance for purchase of raincoat, gumboots, lamps, torch, sweaters, moped, and furniture for the sub-centers, especially the table, chair and almirahs.

The union felt that much more training was needed and all employees must get an opportunity for getting trained- including laboratory work or other multi-skilling.

Transfers should be decided at the district level and should be done by a transfer board.

Persons posted in naxalite affected areas should have special protection and an allowance. Women employees should have an assistance/grievance committee to assist them in case of harassment, which a woman IAS officer or the IAS officers' wife should chair.

Wages should be on par with the central government. Suggested scales are: MPWs 4000-6000; supervisors 4500- 7000, BEE 5500 –9000; Staff nurse 4500- 7000; Paramedical staff/ technician/ pharmacist –4500- 7000. Fixed TA of Rs 400 for MPWs, Rs.600 for supervisors, Rs.800 for BEEs. Also a stationery allowance of Rs 200 for field staff and Rs.1000 annual for ANMs with Rs 100 monthly uniform allowance for nurses were also asked for.

It is noteworthy that the union welcomed multi-skilling and endorsed almost all the recommendations including those on promotion, recruitments and transfers.

Mr. M. Dubey , speaking on behalf of the NMA and president leprosy employees union, also endorsed the recommendations and asked for the absorption of the leprosy employees on par with their current scales and retraining and redeployment in different work.

Another employees association also endorsed the findings but diverged on the recommendation of treating male MPWs in the sub-center as a dying cadre. They noted that the poor performance of male MPWs was largely due to poor training and support. Instead of considering them a dying cadre the department should work for their full utilisation.

The women employees present welcomed the report and emphasised the need for reducing out of pocket expenditures on stationary and on travel. They welcomed the suggestion for two female workers per sub-centre though some of them said that a male worker present is also useful- especially for transport and for moving to distant areas. However they thought that male colleagues should also have immunisation work. The issue of accommodation was major problem for women posted in remote areas. Most sub-centers did not have buildings and most often ANMs were paying house rent out of their own pockets and having to use that same residential premise as stores and as sub center facility. The fixed rent sometimes given was never adequate to pay the rent of a premise where a sub-center with separate space could be conducted. Most often no rent was paid. Buildings for sub centers were therefore a priority.

Civil Society Representatives

CARE India was represented by its senior officials regional manager and programme offices Basanta Kar and Dr. Jose Sool and Dr. Kalyan. CARE, Chhattisgarh felt that the report should have placed more emphasis on giving a greater role to the panchayats not only in planning and oversight but also in governance. Their other major concern was the needs for more inter-sectoral coordination especially with the ICDS programmes. Mitani programme and integration with it also needed to be emphasised.

Members of the State Advisory Committee (SAC) on Health Sector Reforms also attended and participated in the proceedings. These included Mr. D. N. Sharma, secretary ZSS, Durg. Dr. Lakhan Singh, general secretary, Bharat Gyan Vigyan Samiti, Dr. Binayak Sen of PUCL, Dr. Ilina Sen of Rupantar and Mr. Biraj Patnaik, SAC secretary and regional manager, ActionAid.

Ms. Zuleikha of Bharat Gyan Vigyan Samiti, endorsed the report and emphasised the need for paying attention to the problems of ANMs. The need was to reduce their workload and make it more practical. She also expressed her disagreement with the formulation that doctors could be withdrawn from PHCs. Instead she called for enforcement of the provision that doctors should stay in their rural centers of posting. She also called for wider consultation with public representatives in Chhattisgarh

Mr. D. N. Sharma welcomed the report and called for better provisioning of drugs in the facilities. In particular he drew attention to the problems in providing drugs in a timely and adequate manner to the Mitani. Dr. Ilina Sen raised certain issues of methodology. She emphasised the need for a greater role for panchayats.

Dr. Binayak Sen, paediatrician and health activist and civil rights activist commented in detail on the report. The report he said had assumed the existing parameters of the system. Thus for example the fact that doctors in government service are allowed private practice was never questioned and indeed the recommendations seem to have been built taking it as something inevitable. Similarly the role of panchayats that is at current negligible is not questioned. People's role at different levels is also not emphasised. While welcoming the move for a legislative initiative he said that the scope for redressal of denial of health care, even under existing laws like the laws of tort, should be emphasised.

Government officials

Dr. D. K. Sen, joint director welcomed the report and appreciated the detailed nature of the study undertaken. He said that the merging of so many classes of cadre was a big challenge. However some degree of cadre rationalisation was necessary. Multi-skilling, especially with older personnel, nearing retirement as many of the supervisors were would be difficult. But over time and with new recruitments this could be achieved. The recommendations on tenure, transfers, promotions were welcome but again they were difficult to achieve. He questioned the effectiveness of panchayats in being able to govern the health sector and about the suggestions to transfer more functions to them.

Dr. M. R. Pandey was of the opinion that the entire system depended upon effective CMO functioning and a directorate, which could ensure this. The report he felt should strengthen the role of the CMO.

Dr. Sahney spoke on issues of delegation of powers to the chief medical officer. He and other officers from the district felt that the powers equivalent of a joint director should be given to the chief medical officer. He also felt that the greater involvement of panchayats would provide little help though problems would increase.

Dr. Akhilesh Tripathi and Dr. M. Chowdhury represented the medical officers association. On behalf of their associations they welcomed the main recommendation of the report. They specifically endorsed the recommendation for the creation of an administrative cadre and the making of the BMO into a designated post with an allowance for the same. The suggestions for CME and for skills for the CHC level were also welcomed. The failure to complete promotions in a timely manner was considered a major failure of the system.

On discussion even the selection of doctors as a district level cadre was welcomed. The choice of cadre shift and a state cadre being considered only for the administrative cadre or at the time of promotion to class I officer were also suggestions mooted. They also felt that where doctor's accommodation was not provided and where there were no suitable residential premises available – even on rent, then the department could not expect or enforce doctors staying in such places.

Administrators

Mr. Sunil Kumar IAS listened in to a detailed presentation of the report and interrogated many of its recommendations seeking clarifications from time to time. This lasted over two hours on the second day and the ensuing discussion was useful for all present. His most important and emphasised comment was that the role of decentralisation and of local governance had been seriously underplayed. The suggestions related to transfer, promotions purchases etc should be made redundant by transfer of adequate powers and resources to district governments along with powers of appointment and constitution of block and district cadre. The increasing of directors and the structure of the directorate at the state as proposed would lead to just over bureaucratisation and soon there would be a suggestion for a director- general and even further increases – all of which would not contribute to better administration, given the problems of governance

as stated in the report. Mr. Sunil Kumar also suggested that the financial implications of closing the gaps in infrastructure be worked out. Phased out over a five-year period this would be achievable. He estimated that the gap in sub-center building was about Rs 75 crores worth. Finding 15 crores per year to fill this - over the next five years- was possible for the state to achieve.

On public private partnerships also there was a lively discussion. The conclusion was that the challenge was in negotiating the most favourable and sustainable terms for the government. Thus for bringing in institutional care at CHC level it may make more sense for us to build up OT facilities in the public sector and contract in surgeons for an emergency as in most areas private sector nursing homes are also not there. On the other hand where such nursing homes are available we could use them as referral centers, reimbursing the home for treatment of pregnant women below the poverty line. Considerable flexibility is needed and there are administrative challenges in striking the right balance- such that the state fulfils its commitment to provide emergency obstetric care to all.

Speaking next in some detail, Mr. J. P. Mishra, emphasised two recommendations. First was with relevance to the integration of ISMs with the mainstream. The government is investing a large amount in the ISMs infrastructure and manpower, but its use in achieving public health goals is limited and generally these facilities are under-utilised. Careful integration is possible and desirable. The second was the use of GIS to optimise locations of facilities. Substantial increase in access could be gained by this one measure and the report he felt had underplayed this recommendation.

Group Work and Outcomes

The meeting then divided into four groups – each constituted by representative stakeholders from each of the above groups- employees associations, doctors association, senior officials, civil society organisations. Each group finalised a set of priority recommendations in the following four areas where there was still some distance between the positions of the different stakeholder groups – group one was on promotions, cadre restructuring and job descriptions, groups 2 was on transfers and service condition, group three was on training and group four was on delegation of functions and decentralisation. This was incorporated in the next days presentation and also presented to the secretary, health, Govt of Chhattisgarh for follow up action.

Synthesis : Presentation to Union Family Welfare Secretary Mr. Prasanna Hota

Mr. S. K. Mishra chief secretary presided over the presentation and discussions. Dr. Alok Shukla conducted the proceedings and also responded to many questions raised about the report and its recommendations.

Dr. R. K. Rajmani, Director Health Services, welcomed the gathering.

Mr. J. P. Mishra set down the broad issues of systemic reform in the health sector delineating a conceptual model for the same.

Dr. T. Sundararaman then made a presentation of the report. Subsequent to his presentation the employees associations, the leading NGOs and the senior department officials also made their submissions.

The Union Secretary Mr. Prasanna Hota raised the following issues and concerns in relation to specific recommendations. The suggestion for two ANMs in each sub-center is welcome. There are already some sub-centers where two ANMs have been posted. A quick study is needed to document whether service delivery and health outcomes are better as implementing such a suggestion has large financial implications.

Commenting on the large gap between sectors and PHCs, he said that one should consider whether it is worth merging two sectors in some cases and providing for one medical officer to cover both and maintain the public health functions by para-medicals.

Speaking in response to all the submissions he drew upon his own experience as a health administrator to describe how uphill the process of health sector reforms could be. The relevance of the core administrative issues – tenure, transfers, promotions purchases – was well recognised but given the nature of polity, administrators have still been unable to guarantee an adequate process in these areas. One has therefore to continue to look for innovative solutions. As regards transfers a solution may lie in keeping the recruitments specific for each facility or at least for each block. This would be useful for para-medicals especially for ANMs as they can settle down in that area. Having to face transfers is more difficult.

To guarantee tenure is a deeper problem. At all levels- and even a union secretary's post being no exception, one is unable to secure such a basic and essential reform as ensuring tenure in key administrative posts. Therefore a lot of problems require patience and persistence to solve as but we should focus on what changes can be brought about immediately. He specifically emphasised the need to work out the financial implications of many of the recommendations. He assured the audience that the central government appreciates the efforts in health sector reform being made in Chhattisgarh and financially and administratively would be willing to support the state department to the fullest extent.

The chief secretary congratulated the health secretary and his team for the entire effort of the study and the stakeholder dialogues. He said that in the past three years the new state and focussed on infrastructure development and had not paid as much emphasis on the social sectors as was needed. This was particularly true of primary health care. In the coming years this could be corrected. This report and the discussions would go a long way towards strengthening that.

Concluding Session

In the concluding session in the after noon the four groups presented their consensus on reform measures as had emerged from the dialogues. Dr. Alok Shukla then spoke thanking all the participants for their contribution. The only area of divergence that remained within the stakeholders was in the delineating the role of panchayats. In so many other areas – almost a hundred recommendations - there had been almost complete unanimity achieved. This was a big achievement. As regards panchayats he pointed out that decentralisation and the role of panchayats was a constitutional mandate. The question is not whether, not even when, but how. He discussed experiences with decentralisation in Madhya Pradesh especially in education sector to explain the mechanisms of decentralisation that were possible. He also emphasised the need to translate the recommendations of the study and even of the stakeholder dialogues - which were still of a more general nature- into specific draft orders which could be put up for approval by the new government once it had taken office.

ANNEXURE - 4**Participants in Stakeholder Dialogues and Consultation**

on Draft Report of the Workforce Development Study.

06-08 November 2003, State Health Training Centre, Kalibadi.

S. No.	Name	Designation and Organisation
Administration		
1.	Mr. Prasanna Hota, IAS	Secretary, Govt. of India, Dept of Family Welfare.
2.	Mr. S. K. Mishra, IAS	Chief Secretary, Govt. of Chhattisgarh.
3.	Mr. Sunil Kumar, IAS	Secretary, Govt. of Chhattisgarh, Chief Minister's Office.
4.	Dr. Alok Shukla, IAS	Secretary, Government of Chhattisgarh, Dept. of Health and Family Welfare.
5.	Mr. Amit Agrawal, IAS	Secretary, Govt. of Chhattisgarh, Dept of Information Technology.
6.	Mr. J. P. Mishra	Consultant, European Commission, EC Assisted Health and Family Welfare Programmes in India
7.	Dr. Pramod Singh	Deputy Secretary, Government of Chhattisgarh, Dept. of Health and Family Welfare.
8.	Dr. A. K. Agnihotri	Sr. Regional Director, GoI Regional Office for Health & Family Welfare, Bhopal
Directorate of Health		
9.	Dr. R. K. Rajmani	Director, Health Services, Government of Chhattisgarh.
10.	Dr. G.S. Badesa	Director, Indian System of Medicines, Government of Chhattisgarh.
11.	Dr. D. K. Sen	Joint Director, Health Services, Govt. of Chhattisgarh
12.	Dr. Manuraj Pandey	Joint Director & Superintendent, Medical College, Raipur.
13.	Dr. H. L. Ratre	Joint Director, Health Services, Govt. of Chhattisgarh
14.	Dr. B. S. Sarwa	Joint Director, Health Services, Govt. of Chhattisgarh
15.	Dr. I. S. Bais	Deputy Director, Health Services, Govt. of Chhattisgarh
16.	Dr. R. N. Netam	CMHO, Rajnandgaon, Chhattisgarh
17.	Dr. R. R. Sahni	CMHO, Bastar, Chhattisgarh
18.	Dr. Anil Dawe	Spl. Surgeon, Raipur, Chhattisgarh
19.	Dr. B. Dewangan	Deputy Director, Health Services, Govt. of Chhattisgarh

20.	Ms. Geetanjali Agrawal	State NGO Coordinator, RCH Programme, Chhattisgarh
21.	Dr. K. Madan Gopal	Ag. Chief Advisor, Danida Health Support Unit.
22.	Ms. Ira Saraswat	Adviser, Danida Health Support Unit, Raipur Chhattisgarh
23.	Mr. Sanjeev Chakravarti	Adviser, Danida Health Support Unit, Raipur Chhattisgarh

Medical Professionals/ Doctors Association Representatives

24.	Dr. A. K. Sharma	HoD, Surgery, Medical College, Raipur.
25.	Dr. Mrs. N. K. Gandhi	HoD, Preventive & Social Medicine, Medical College, Raipur.
26.	Dr. Akhilesh Thripathi	DMO & BMO, Mahasamund. (Chhattisgarh Medical Officer's Association)
27.	Dr. M. Chowdhary	DMO, Rajnandgaon. (Chhattisgarh Medical Officer's Association)
28.	Dr. R. K. Chandrawanshi	DTO, Kanker. (Chhattisgarh Medical Officer's Association)

Employees/Employees Association Representatives

29.	Dr. Chetan Daharia	DIO, Dantewara. (Chhattisgarh Medical Officer's Association)
30.	Ms. Shalini. P. Raj	DPHNO, Jagdalpur.
31.	Mr. O. P. Sharma	President, Chhattisgarh Swasthya Karmachari Sangh.
32.	Mr. S. K. Mishra	Vice President, Chhattisgarh Swasthya Karmachari Sangh.
33.	Mr. Santhosh Pathak	General Secretary, CG Swasthya Karmachari Sangh.
34.	Mr. U. S. Ganguly	President, CG Swasthya Karmachari Sangh Raipur Dist.
35.	Mr. Ajay Sahni	General Secretary, CG Swasthya Karmachari Sangh, Raipur Dist.
36.	Ms. Prdeepthi Sarkar	State Convenor, Ophth. Asst Wing, CG Swasthya Karmachari Sangh.
37.	Mr. Syed Asalam	State Joint Secreary, Chhattisgarh Swasthya Karmachari Sangh.
38.	Mr. I. R. Sahu	President, Health Union, Dhamda, Durg.
39.	P. P. Kashyap	BETO, Palmgarh, Janjgir.
40.	Mr. S. R. Verma	BEE, Bhatapara. (Treasurer, Medical & Multipurpose Health Workers wing, Chhattisgarh Karmachari Congress.)

41.	Mr. Mansingh Dubey	Assistant-III, Raipur. (Provincial Secreary, Chhattisgarh Karmachari Congress.)
42.	Mr. A. N. Shukla	Supervisor, Raipur (Convenor, Medical & Multipurpose Heath Workers wing, Karmachari Congress.)
43.	Mr. Pramod Tiwari	NMA, Mahasamund. (President, State Leprosy Employees Union)
44.	Mr. K. R. Bhosle	BEE, Dhamtari.
45.	Ms. Laxmi Sarkar	LHV, CHC Abhanpur. (Employees Association)
46.	Mr. K.K.Tiwari	Superwiser, Ghumaka, Rajnandgaon. (Treasurer, Health Emplpyees Association, Rajnandgaon.)
47.	Ms. S. P. Lal	ANM, Lawan, Raipur.
48.	Ms. R. Begum	ANM, Ghumka, Rajnandgaon.

Civil society Representatives

49.	Mr. Biraj Patnaik	Manager, ActionAid India, Chhattisgarh
50.	Dr. Lakhan Singh	Secretary, BGVS Chhattisgarh.
51.	Dr. Ilina Sen	Rupantar, Raipur.
52.	Dr. Binayak Sen	PUCL, Chhattisgarh.
53.	Dr. Saibal Jana	MO incharge, Shahid Hospital, Dalli Rajhara.
54.	Mr. D. N. Sharma	Secreatary, Zila Saksharata Samiti Durg.
55.	Mr. Basanta Kar	State Representative, CARE Chhattisgarh.
56.	Dr. Jose Sool	Regional Manager, CARE Chhattisgarh.
57.	Dr. Kalyan	CBO, CARE Chhattisgarh, Bilaspur.
58.	Ms. Julekha Jabeen	Bharat Gyan Vigyan Samithi, Chhattisgarh.

State Health Resource Centre Participants

59.	Dr. T. Sundararaman	Director, SHRC
60.	Dr. Shailendra Patne	Lecturer, Medical College, Bhopal.
61.	Dr. Premanjali Deepti Singh	Programme Coordinator, SHRC.
62.	Mr. V. R. Raman	Programme Coordinator, SHRC.

ANNEXURE - 5
LIST OF ABBREVIATIONS

ANC	-	Antenatal care
ANM	-	Auxiliary Nurse Midwife (Same as female MPW)
API	-	Annual Parasite Index
BEE	-	Block extension Educator
BMO	-	Block Medical Officer
BSE	-	Blood Smear examination for malarial parasite
CHMO	-	Chief health & Medical officer (District Head)
HA	-	Health Assistant (Same as Sector Superior Male)
HSC	-	Health Subcentre
IEC	-	Information, education, Communication
IUCD	-	Intrauterine contraceptive device
LHV	-	Lady Health Visitor (Same as Sector Superior Female)
Mitanin	-	Community Health Worker in the Chhattisgarh Programme
MO	-	Medical Officer
MPW	-	Multipurpose Health Worker
MTP	-	Medical Termination of Pregnancy
O&M	-	Organization & Motivation
OC	-	Oral contraceptive
OT	-	Operation Theatre
PGMO	-	Post Graduate Medical officer
PHC	-	Primary Health Centre
RCH	-	Reproductive & Child Health
RTI	-	Reproductive Tract Infection
SC	-	Sub Centre
SPR	-	Slight Positivity Rates
SSF	-	Sector Superior Female
SSM	-	Sector Superior Male
STD	-	Sexually Transmitted Disease
TBA	-	Traditional Birth Attendant
TT	-	Tetanus Toxoid

SHRC PUBLICATIONS

LIST OF MITANIN PROGRAMME TRAINING MODULES

Janta ka swasthya, Janta ke haath

(Introductory book on health and Mitanin Programme)

Hamara Hak, Hamari Hakikat

(Introduction to public health services and facilities)

Hamare Bachche, Unki Sehat

(Basics of child health action)

Mitanin Tor Mor Goth

(Basics of women's health action)

Chalbo Mitanin Sang - 1

(Local planning for malaria and gastroenteritis)

Chalbo Mitanin Sang - 2

(Control of Chronic Communicable Diseases control T. B. & Leprosy)
(In Print)

Mitanin Ke Dawa Peti

(An introduction to first contact curative care)

Kahat Hey Mitanin

(A pictorial book with key Messages that Mitanins can use for local communication)

Modules on

Local health Planning,

Herbal & Household Remedies

and Disabilities

are also planned.

MODULES PREPARED FOR TRAINERS AND PROGRAMME OFFICERS OF MITANIN PROGRAMME

Prerak Prashikshan Sandarshika

(For training the facilitators to guide Mitanin Selection)

Mitanin Prashikshan Pustika

(A handbook for Mitanin trainers and programme officers)

Mitanin Nigrani Rananeeti

(A handbook on Monitoring the Mitanin programme)

PUBLICATIONS FOR STRENGTHENING PUBLIC HEALTH SYSTEM

(Authored by SHRC and Published by
Chhattisgarh Basic Health Services Project)

Dai Training Module

(for Traditional Birth Attendants Training)

Swasthya ki Baat Sabke Saath

(for MPW's in service training on community participation in health programmes)

Manak Chikitsa Sandarshika

(Standard Treatment Guideliness for MPWs)

Essential Drug List

(Chhattisgarh Graded Essential Drug List-2003)

Chhattisgarh State Drug Formulary

Standard Treatment Guidelines for Medical Officers

SHRC WORKING PAPERS

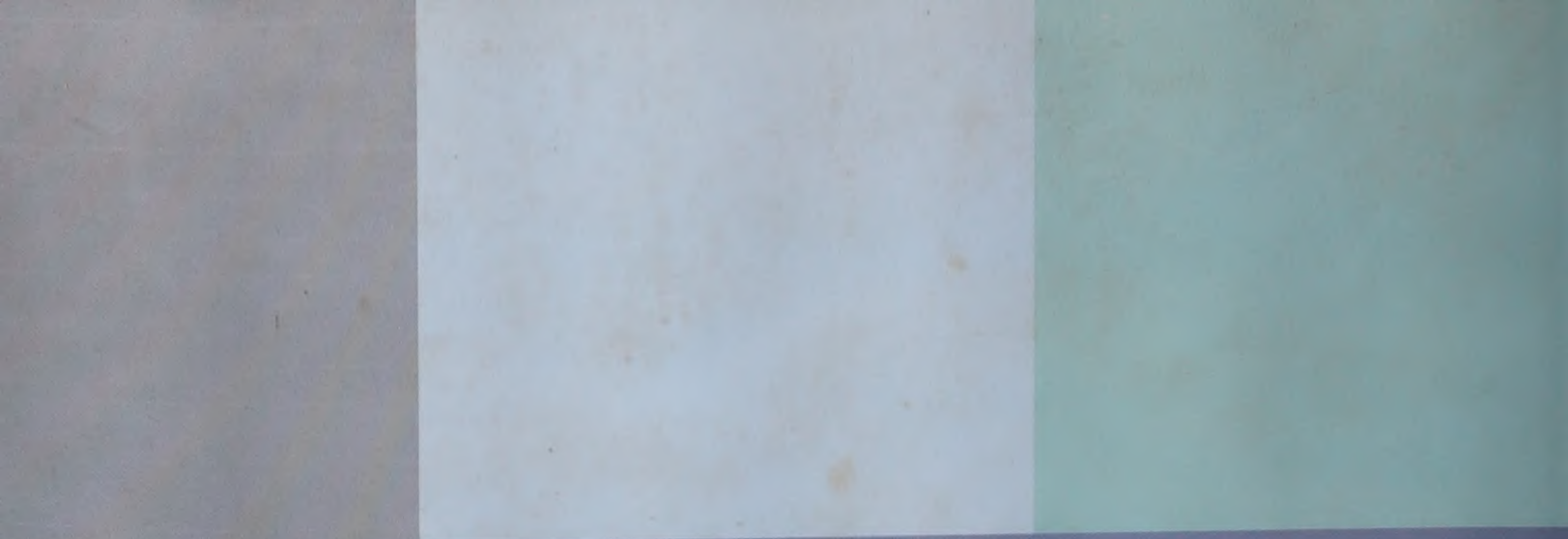
Malaria- Operational Research

(Proceedings of malaria operational research workshop, Korba)

Mitanin programme: Conceptual Issues and Operational Guidelines

Strengthening Public Health Systems

(Issues of workforce management , rationalisation of services and human resource development in the public health system)



State Health Resource Centre is an autonomous institution funded by the state government as part of the sector investment programme. It is functioning as additional technical capacity to the Department of Health and Family Welfare, Govt. of Chhattisgarh. The SHRC is a joint initiative of the State Government of Chhattisgarh and Action Aid India. Other than the Mitandin Programme, the SHRC is initiating a wide range of activities as part of the Health Sector Reforms Programme and as part of its contribution to strengthening public health systems for achieving comprehensive universal primary health care.

